Building Healthier Tomorrows

Agenda

- May Packets/Application Renewals
- Record Keeping/Regulations
- Crediting Foods/Infant Reminders

Agenda

May Packets/Application Renewals

Record Keeping/Regulations

Crediting Foods/Infant Reminders

May Packets

- IEFs – Revised – use FY 2016 form
- Letters to Households
- Income Guidelines – effective July 1
- Enrollment Form
- Claim Worksheets
- Site Review Forms
- Permanent Agreements (Additional Signature Page Maybe Required.)

FY 2016 Applications

- Must enter and submit application and all supporting documents by **June 15, 2015**.
- Remember to **mail** pages with **original signatures** only if changed.

Responsible Individual or Principal - 1

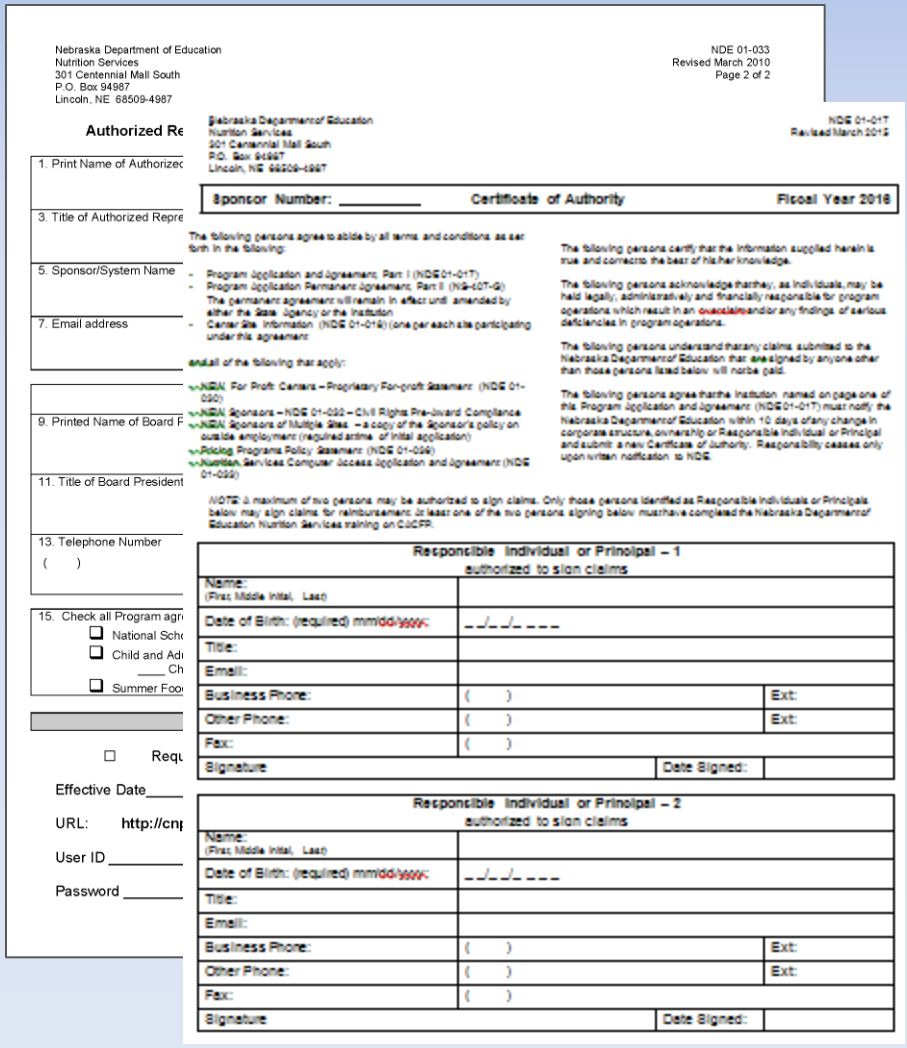
	Salutation	First Name	M.I.	Last Name
14. Name:		Linda	L	Smith

- New responsible individuals must submit new Computer Access Application form.
  - **DO NOT use someone else's password.**

Responsible Individuals

New responsible individual or principal = must apply for a new User ID and password

New person with signing authority **must** attend full day CACFP training within 4 months.



Nebraska Department of Education
Nutrition Services
301 Centennial Mall South
P.O. Box 94987
Lincoln, NE 68509-4987

NDE 01-033
Revised March 2010
Page 2 of 2

Authorized Re

1. Print Name of Authorized
3. Title of Authorized Repre
5. Sponsor/System Name
7. Email address
9. Printed Name of Board P
11. Title of Board President
13. Telephone Number ( )
15. Check all Program agr
☐ National Scho
☐ Child and Ad
____ Ch
☐ Summer Foo
☐ Requ
Effective Date____
URL: http://cnp
User ID _____
Password _____

Nebraska Department of Education
Nutrition Services
301 Centennial Mall South
P.O. Box 94987
Lincoln, NE 68509-4987

NDE 01-017
Revised March 2015

Sponsor Number: _____ Certificate of Authority Fiscal Year 2016

The following persons agree to abide by all terms and conditions as set forth in the following:

- Program Application and Agreement, Part I (NDE 01-017)
- Program Application Permanent Agreement, Part II (NS-607-G)
  The permanent agreement will remain in effect until amended by either the State Agency or the Institution.
- Center Site Information (NDE 01-016) (one per each site participating under this agreement

and all of the following that apply:

- NSLP, For Profit Centers – Proprietary For-profit Statement (NDE 01-090)
- NSLP Sponsors – NDE 01-032 – Civil Rights Pre-Award Compliance
- NSLP Sponsors of Multiple Sites – a copy of the Sponsor's policy on outside employment (required at time of initial application)
- Policing Programs Policy Statement (NDE 01-094)
- Nutrition Services Computer Access Application and Agreement (NDE 01-099)

The following persons certify that the information supplied herein is true and correct to the best of his/her knowledge.

The following persons acknowledge that they, as individuals, may be held legally, administratively and financially responsible for program operations which result in an overclaim and/or any findings of serious deficiencies in program operations.

The following persons understand that any claims submitted to the Nebraska Department of Education that are signed by anyone other than those persons listed below will not be paid.

The following persons agree that the institution named on page one of this Program Application and Agreement (NDE 01-017) must notify the Nebraska Department of Education within 10 days of any change in corporate structure, ownership or Responsible Individual or Principal and submit a new Certificate of Authority. Responsibility ceases only upon written notification to NDE.

NOTE: A maximum of two persons may be authorized to sign claims. Only those persons identified as Responsible Individuals or Principals below may sign claims for reimbursement. At least one of the two persons signing below must have completed the Nebraska Department of Education Nutrition Services training on CACFP.

Responsible Individual or Principal – 1 authorized to sign claims			
Name: (First, Middle Initial, Last)			
Date of Birth: (required) mm/dd/yyyy:	_ _/_ _/_ _ _ _		
Title:			
Email:			
Business Phone:	( )	Ext:	
Other Phone:	( )	Ext:	
Fax:	( )		
Signature		Date Signed:	

Responsible Individual or Principal – 2 authorized to sign claims			
Name: (First, Middle Initial, Last)			
Date of Birth: (required) mm/dd/yyyy:	_ _/_ _/_ _ _ _		
Title:			
Email:			
Business Phone:	( )	Ext:	
Other Phone:	( )	Ext:	
Fax:	( )		
Signature		Date Signed:	

Renewal Application

- NDE cannot make changes to your application
- Change of address requires further follow-up be sure to contact NDE
- Errors on application will be returned to center by e-mail
  - Ensure email in Sponsor Application is current
    - Responsible Individuals 1 & 2

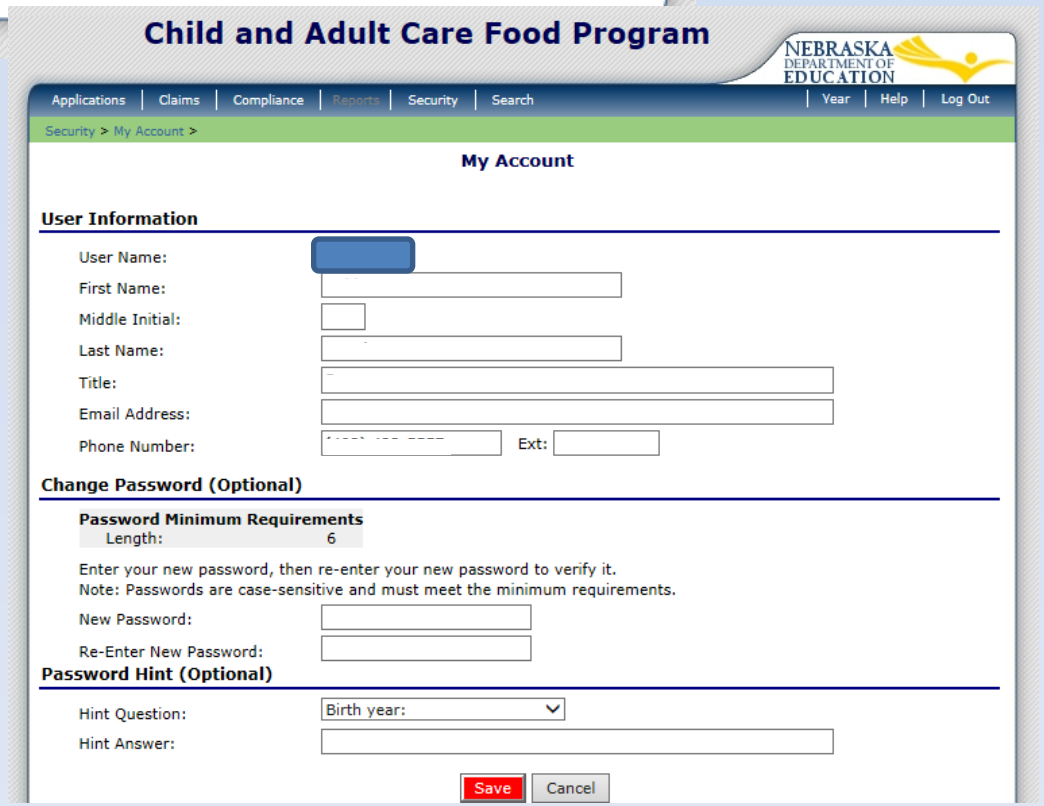
Omaha, NE 68111-1862 Packet Status: Not Submitted

Packet Assigned To: Susanne Schnitzer

Action	Form Name	Latest Version	Status
View	✔ Sponsor Application	Original	Approved
Details	Staff Profile		
View	✔ Sponsor Budget Detail	Original	Approved
Details	➡ Checklist Summary (5)		
Details	Application Packet Notes		
Details	Attachment List		

	Approved	Pending	Return for Correction	Denied	Withdrawn/ Closed	Error	Total Applications
Site Application(s)	0	1	0	0	0	0	1

< Back | Submit for Approval | Approve | Return | Deny



Keep email address current

Password change

Renewal Application

- SAM/DUNS registration is good for one year.
- DUNS number does not change year-to-year
- **MUST** re-register every year @ SAM.gov
- DUNS re-registration date must be submitted in the online application
- Centers receive reminder e-mail
- Registration is FREE

DUNS

Reporting Requirements

Dun and Bradstreet Data Universal System Number (nine (9) digit DUNS Number): 123456789

Click here if this number does not match your records. Please contact NDE to change the DUNS number. Normally, the DUNS number will not change unless the sponsor has changed their Federal Tax ID number (FTIN).

Physical address zip code from the System for Awards Management (SAM) Registration:

Click www.usps.com to verify the zip code + 4.

Date the Registration was completed or renewed: 07/01/2015

Sponsors are strongly encouraged to maintain a copy of the confirmation email received from SAM Registration.

☐ By checking the confirmation box and providing the date of registration or renewal, the Sponsor is confirming successful online registration or renewal in SAM Registration.

For further instructions, see Download Forms, document SAM_SNP.

Budget Detail

- Recommend <u>50%</u> of CACFP income be budgeted for food expenses
- NDE **CANNOT** make changes; only approve or deny

Budget Version: Original

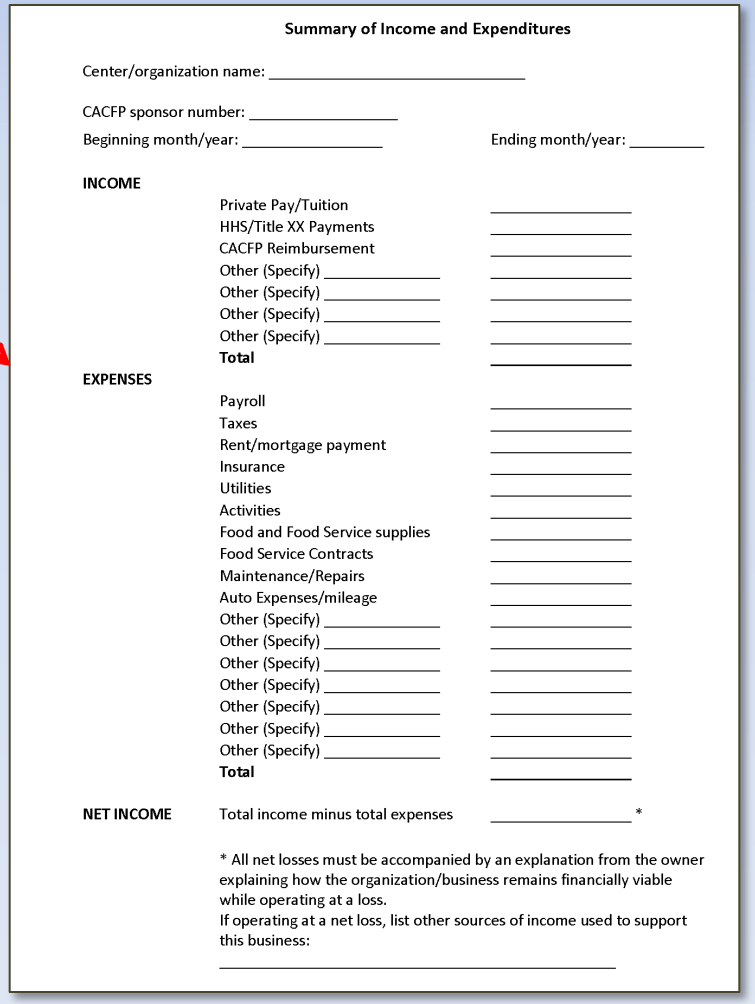
		Sponsor Complete This Column	FOR STATE USE ONLY Approved
A. ANTICIPATED ANNUAL CACFP REIMBURSEMENT			
1.	Prior Year CACFP Reimbursement	$61,598.46	$0.00
B. OPERATING EXPENSES			
	SALARIES AND BENEFITS		
1.	Salaries, Benefits & Taxes (Total from Staff Profile)	$78,257.13	$0.00
	FOOD SERVICE		
2.	Other (Specify)	$0.00	$0.00
3.	Food Purchases	$75,000.00	$0.00
4.	Food Contracts (vendor, school)	$0.00	$0.00
5.	Nonfood Supplies (napkins, soap, disposable plates, gloves, etc.)	$4,500.00	$0.00
6.	Equipment (freezer, stove, refrigerator, etc.)	$0.00	$0.00
	Total Operating Costs	$157,757.13	$0.00
C. NET OPERATING AMOUNT			
1.	Difference (F2 - Total Operating Costs)	$-97,757.13	$0.00
D. ADMINISTRATIVE EXPENSES			
1.	Printing, Reproduction	$0.00	$0.00
2.	Data Processing	$0.00	$0.00
3.	Mileage	$500.00	$0.00
	Total Administrative Costs	$500.00	$0.00

Financial Statements

- Acceptable statements:
  - NDE's Summary of Income and Expenditures form (preferred)
  - Accounting software
  - Year-end tax statement
  - Audit report
  - Bank statement

Balance sheets NOT acceptable

Handout



Summary of Income and Expenditures

Center/organization name: _____

CACFP sponsor number: _____

Beginning month/year: _____ Ending month/year: _____

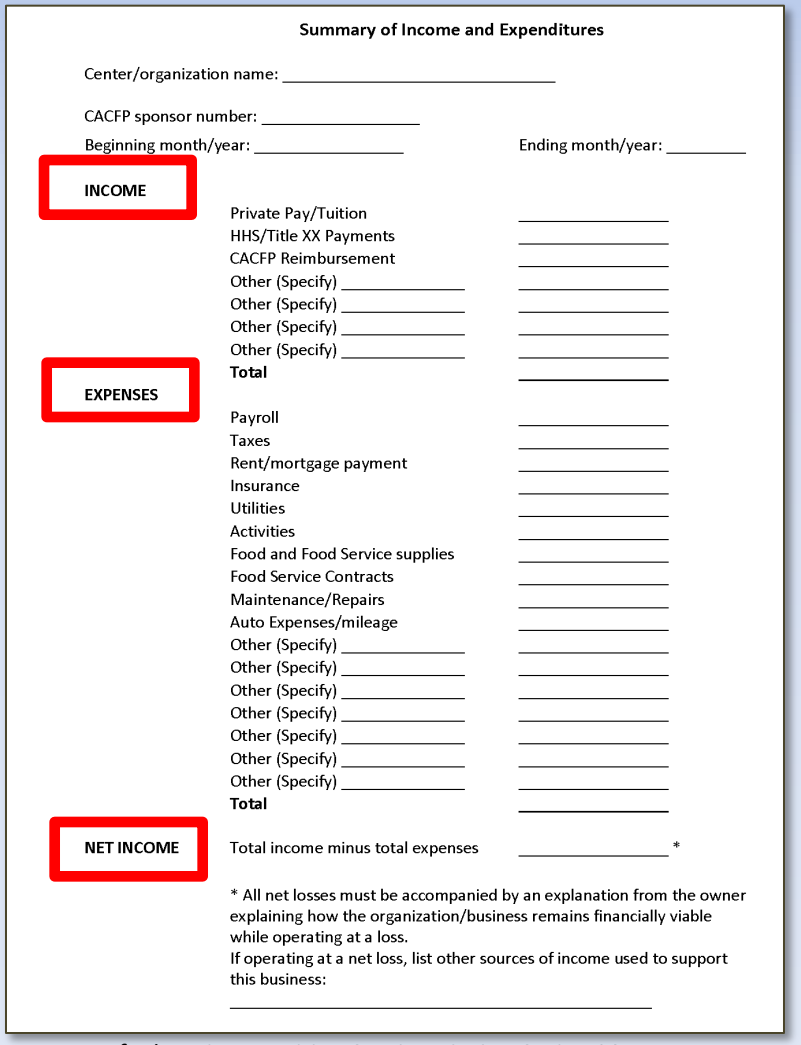
INCOME		
	Private Pay/Tuition	
	HHS/Title XX Payments	
	CACFP Reimbursement	
	Other (Specify) _____	
	Other (Specify) _____	
	Other (Specify) _____	
	Other (Specify) _____	
	Total	
EXPENSES		
	Payroll	
	Taxes	
	Rent/mortgage payment	
	Insurance	
	Utilities	
	Activities	
	Food and Food Service supplies	
	Food Service Contracts	
	Maintenance/Repairs	
	Auto Expenses/mileage	
	Other (Specify) _____	
	Other (Specify) _____	
	Other (Specify) _____	
	Other (Specify) _____	
	Other (Specify) _____	
	Other (Specify) _____	
	Other (Specify) _____	
	Total	
NET INCOME	Total income minus total expenses	*

* All net losses must be accompanied by an explanation from the owner explaining how the organization/business remains financially viable while operating at a loss.
If operating at a net loss, list other sources of income used to support this business:
_____

Financial Statements

- Not necessary to have an expense for every category
- MUST show financial viability

Handout



Summary of Income and Expenditures

Center/organization name: _____

CACFP sponsor number: _____

Beginning month/year: _____ Ending month/year: _____

INCOME

Private Pay/Tuition	_____
HHS/Title XX Payments	_____
CACFP Reimbursement	_____
Other (Specify) _____	_____
Other (Specify) _____	_____
Other (Specify) _____	_____
Other (Specify) _____	_____
Total	_____

EXPENSES

Payroll	_____
Taxes	_____
Rent/mortgage payment	_____
Insurance	_____
Utilities	_____
Activities	_____
Food and Food Service supplies	_____
Food Service Contracts	_____
Maintenance/Repairs	_____
Auto Expenses/mileage	_____
Other (Specify) _____	_____
Other (Specify) _____	_____
Other (Specify) _____	_____
Other (Specify) _____	_____
Other (Specify) _____	_____
Other (Specify) _____	_____
Other (Specify) _____	_____
Total	_____

NET INCOME

Total income minus total expenses _____ *

* All net losses must be accompanied by an explanation from the owner explaining how the organization/business remains financially viable while operating at a loss.
If operating at a net loss, list other sources of income used to support this business:

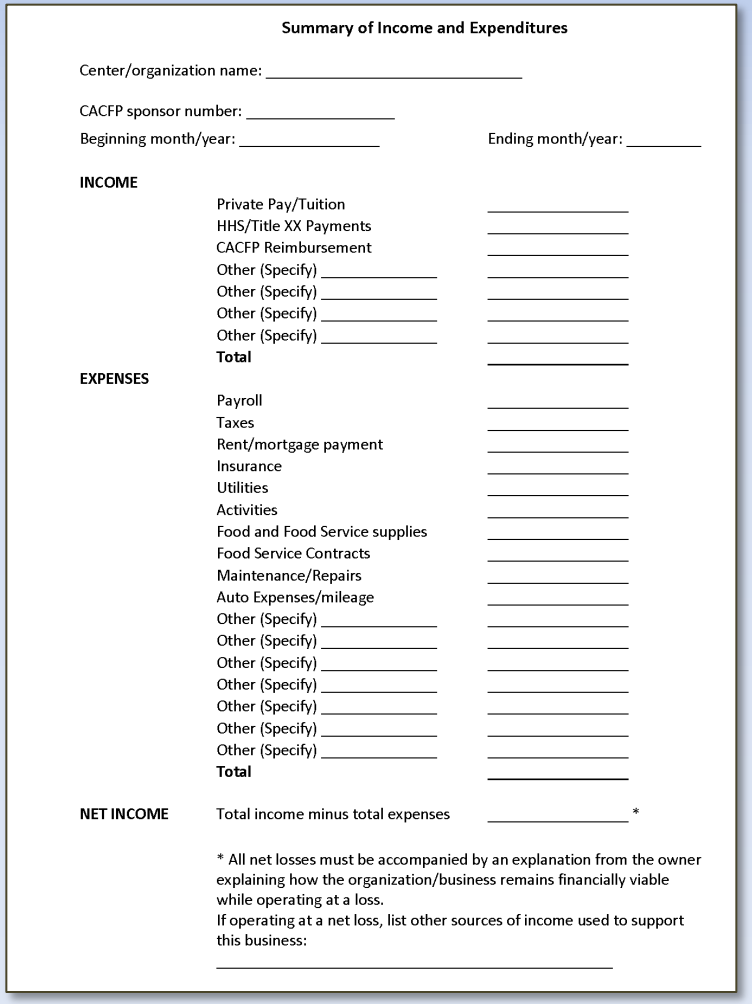
_____

Financial Statements

Income & Expenses – most recent two months (or more) of entire business

- Income – private pay, title XX, grants, donations
- All expenses, including:
  - Rent, utilities
  - Salaries (all)
  - Food costs
  - General day care expenses

Handout



Summary of Income and Expenditures

Center/organization name: _____

CACFP sponsor number: _____

Beginning month/year: _____ Ending month/year: _____

INCOME		
	Private Pay/Tuition	_____
	HHS/Title XX Payments	_____
	CACFP Reimbursement	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Total	_____
EXPENSES		
	Payroll	_____
	Taxes	_____
	Rent/mortgage payment	_____
	Insurance	_____
	Utilities	_____
	Activities	_____
	Food and Food Service supplies	_____
	Food Service Contracts	_____
	Maintenance/Repairs	_____
	Auto Expenses/mileage	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Other (Specify) _____	_____
	Total	_____
NET INCOME	Total income minus total expenses	_____ *

* All net losses must be accompanied by an explanation from the owner explaining how the organization/business remains financially viable while operating at a loss.
If operating at a net loss, list other sources of income used to support this business:
_____

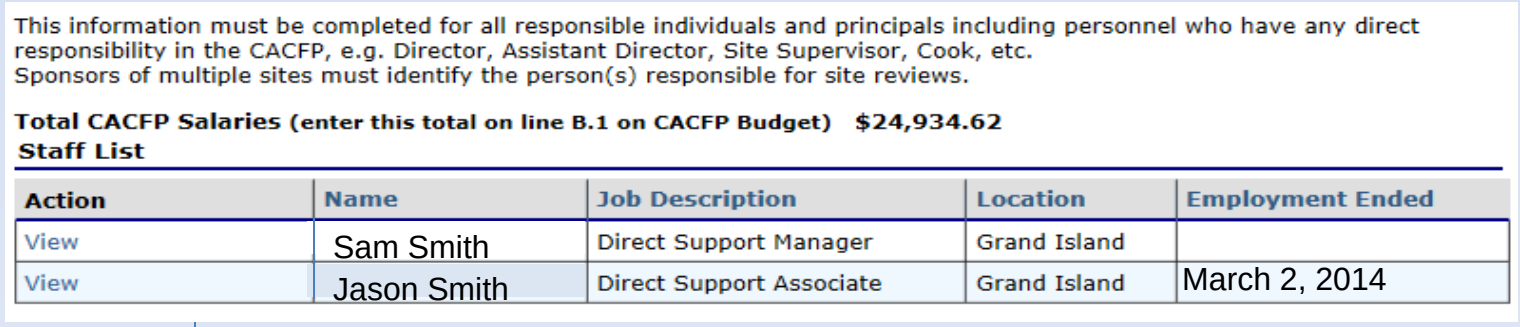
Financial Viability:
Questions to answer

- Using savings to cover a deficit?
- Why the loss of income?
- How do you plan to cover losses if they continue?

- Additional profit/loss statements, bank statements, etc. may be required
- Monitored by NDE, State Auditors and USDA

Staff Profile

- Staff Profile must be current.
- Anyone who does work related to CACFP needs to be listed in the staff profile.
- Must have employees in staff profile to count time certification toward meeting non-profit.
- If someone quits, enter their termination date.
- New hire? Enter the information for the new employee.



This information must be completed for all responsible individuals and principals including personnel who have any direct responsibility in the CACFP, e.g. Director, Assistant Director, Site Supervisor, Cook, etc.
Sponsors of multiple sites must identify the person(s) responsible for site reviews.

Total CACFP Salaries (enter this total on line B.1 on CACFP Budget) **$24,934.62**

Staff List

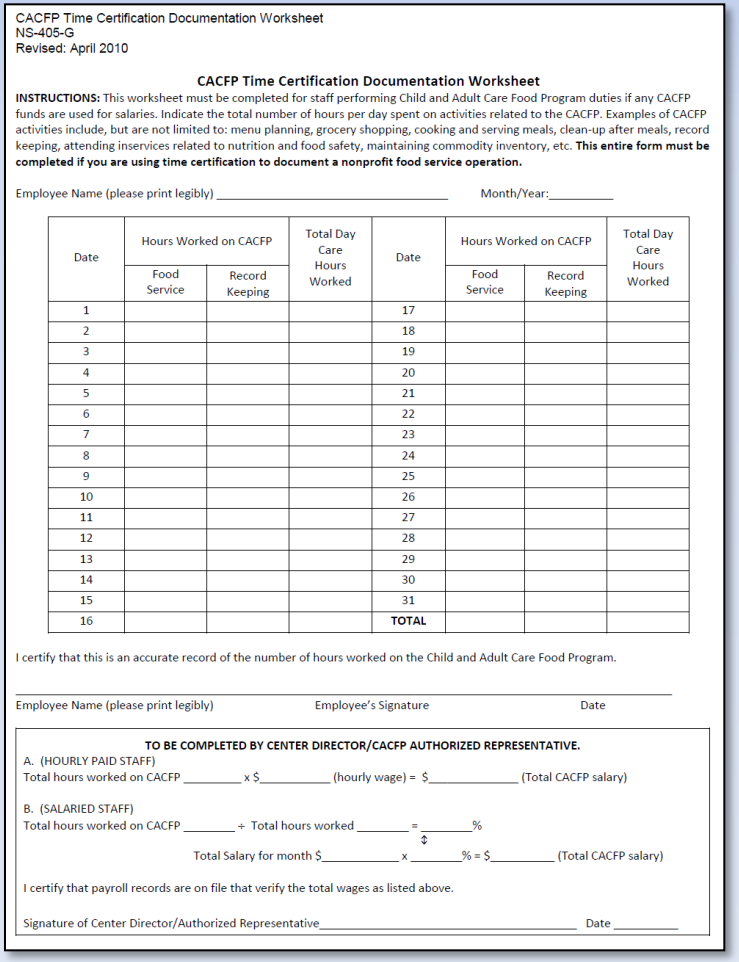
Action	Name	Job Description	Location	Employment Ended
View	Sam Smith	Direct Support Manager	Grand Island	
View	Jason Smith	Direct Support Associate	Grand Island	March 2, 2014

Time Certification

Time certification must be completed daily by employees if any portion of their wages come from CACFP. *

** If necessary to document a nonprofit food service operation*

Handout



CACFP Time Certification Documentation Worksheet
NS-405-G
Revised: April 2010

CACFP Time Certification Documentation Worksheet

INSTRUCTIONS: This worksheet must be completed for staff performing Child and Adult Care Food Program duties if any CACFP funds are used for salaries. Indicate the total number of hours per day spent on activities related to the CACFP. Examples of CACFP activities include, but are not limited to: menu planning, grocery shopping, cooking and serving meals, clean-up after meals, record keeping, attending inservices related to nutrition and food safety, maintaining commodity inventory, etc. **This entire form must be completed if you are using time certification to document a nonprofit food service operation.**

Employee Name (please print legibly) _____ Month/Year:_____

Date	Hours Worked on CACFP		Total Day Care Hours Worked	Date	Hours Worked on CACFP		Total Day Care Hours Worked
	Food Service	Record Keeping			Food Service	Record Keeping	
1				17			
2				18			
3				19			
4				20			
5				21			
6				22			
7				23			
8				24			
9				25			
10				26			
11				27			
12				28			
13				29			
14				30			
15				31			
16				**TOTAL**			

I certify that this is an accurate record of the number of hours worked on the Child and Adult Care Food Program.

Employee Name (please print legibly) Employee's Signature Date

TO BE COMPLETED BY CENTER DIRECTOR/CACFP AUTHORIZED REPRESENTATIVE.

A. (HOURLY PAID STAFF)
Total hours worked on CACFP _____ x $_____ (hourly wage) = $_____ (Total CACFP salary)

B. (SALARIED STAFF)
Total hours worked on CACFP _____ ÷ Total hours worked _____ = _____%

Total Salary for month $_____ x _____% = $_____ (Total CACFP salary)

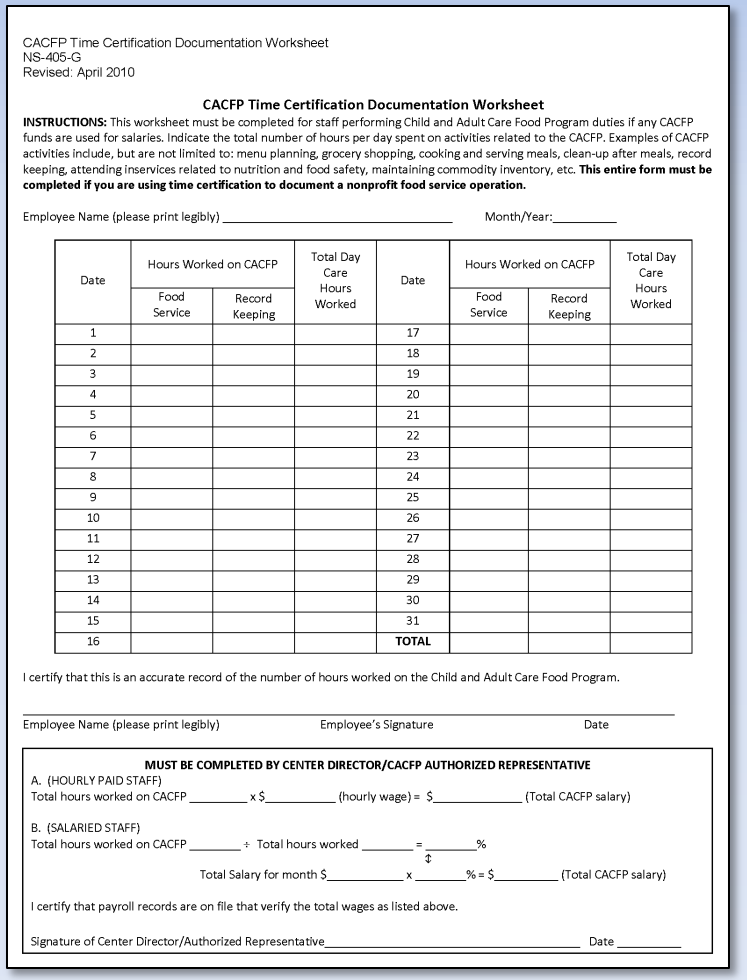
I certify that payroll records are on file that verify the total wages as listed above.

Signature of Center Director/Authorized Representative_____ Date _____

Time Certification

Hours Worked on CACFP		Total Day Care Hours Worked
Food Service	Record Keeping	
3	0	7.5
5	1	7.5

Document number of hours, not time of day.



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INSTRUCTIONS: This worksheet must be completed for staff performing Child and Adult Care Food Program duties if any CACFP funds are used for salaries. Indicate the total number of hours per day spent on activities related to the CACFP. Examples of CACFP activities include, but are not limited to: menu planning, grocery shopping, cooking and serving meals, clean-up after meals, record keeping, attending inservices related to nutrition and food safety, maintaining commodity inventory, etc. **This entire form must be completed if you are using time certification to document a nonprofit food service operation.**

Employee Name (please print legibly) _____ Month/Year:_____

Date	Hours Worked on CACFP		Total Day Care Hours Worked	Date	Hours Worked on CACFP		Total Day Care Hours Worked
	Food Service	Record Keeping			Food Service	Record Keeping	
1				17			
2				18			
3				19			
4				20			
5				21			
6				22			
7				23			
8				24			
9				25			
10				26			
11				27			
12				28			
13				29			
14				30			
15				31			
16				**TOTAL**			

I certify that this is an accurate record of the number of hours worked on the Child and Adult Care Food Program.

_____
Employee Name (please print legibly) Employee's Signature Date

MUST BE COMPLETED BY CENTER DIRECTOR/CACFP AUTHORIZED REPRESENTATIVE

A. (HOURLY PAID STAFF)
Total hours worked on CACFP _____ x $_____ (hourly wage) = $_____ (Total CACFP salary)

B. (SALARIED STAFF)
Total hours worked on CACFP _____ ÷ Total hours worked _____ = _____%
↕
Total Salary for month $_____ x _____% = $_____ (Total CACFP salary)

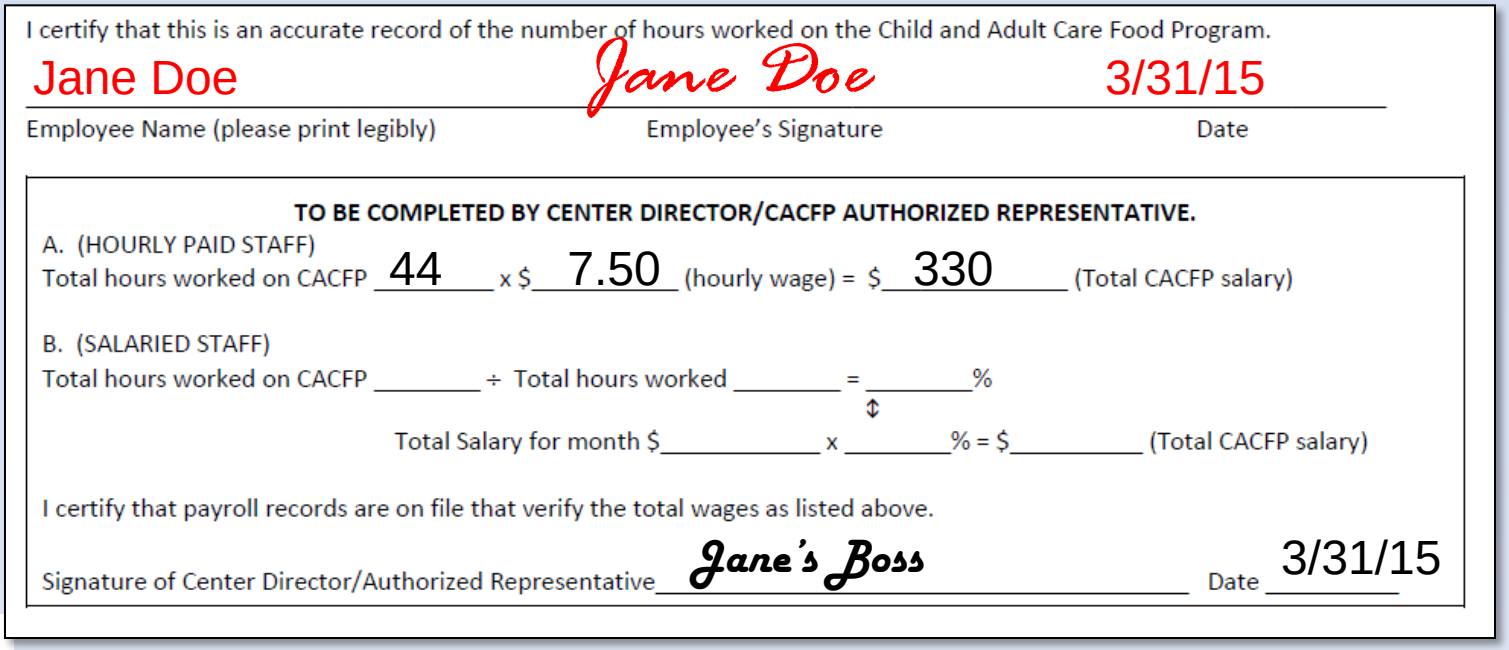
I certify that payroll records are on file that verify the total wages as listed above.

Signature of Center Director/Authorized Representative_____ Date _____

Time Certification

Bottom portion must be completed and signed by the supervisor.

Employee **AND** employer must sign.



I certify that this is an accurate record of the number of hours worked on the Child and Adult Care Food Program.

Jane Doe | Jane Doe | 3/31/15

Employee Name (please print legibly) | Employee's Signature | Date

TO BE COMPLETED BY CENTER DIRECTOR/CACFP AUTHORIZED REPRESENTATIVE.

A. (HOURLY PAID STAFF)

Total hours worked on CACFP 44 x $ 7.50 (hourly wage) = $ 330 (Total CACFP salary)

B. (SALARIED STAFF)

Total hours worked on CACFP _____ ÷ Total hours worked _____ = _____%

Total Salary for month $_____ x _____% = $_____ (Total CACFP salary)

I certify that payroll records are on file that verify the total wages as listed above.

Signature of Center Director/Authorized Representative Jane's Boss Date 3/31/15

Site Application

Packet Assigned To:

Action	Form Name	Latest Version	Status
View	✔ Sponsor Application	Rev. 1	Approved
Details	Staff Profile		
View	✔ Sponsor Budget Detail	Original	Approved
Details	✔ Checklist Summary (4)		
Details	Application Packet Notes		
Details	Attachment List		

	Approved	Pending	Return for Correction	Denied	Withdrawn/ Closed	Error	Total Applications
Site Application(s)	1	0	0	0	0	0	1

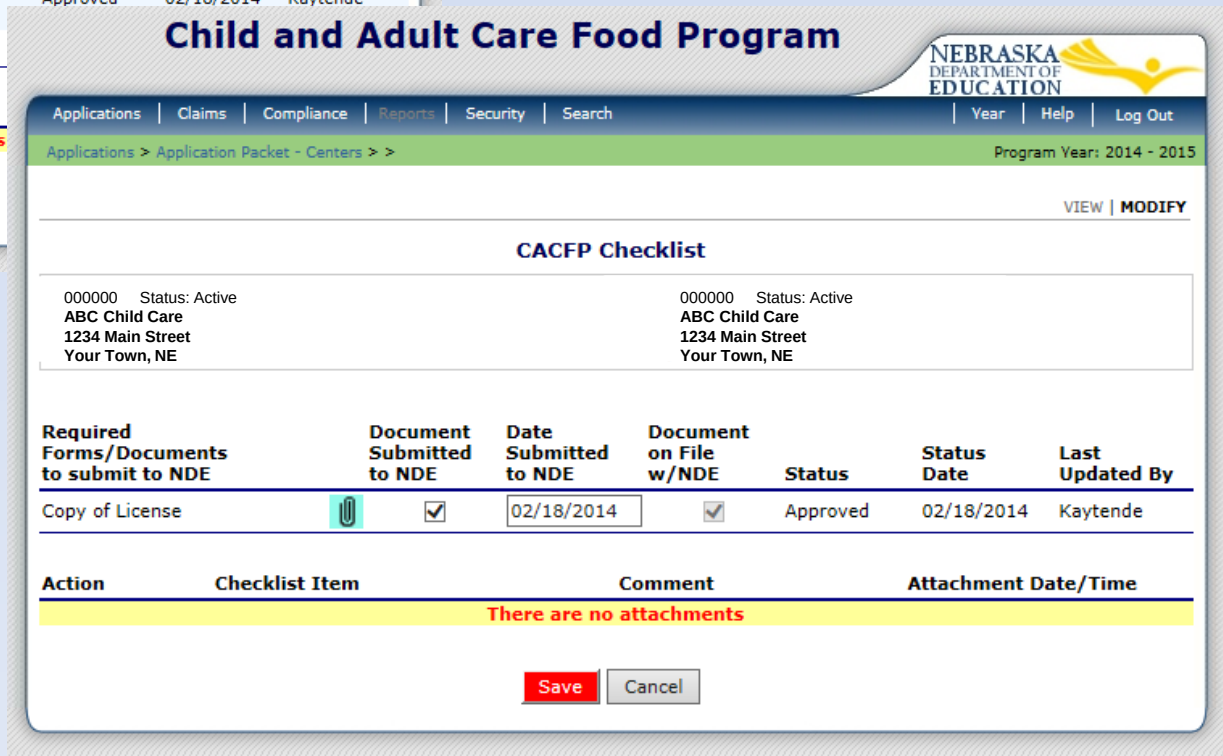
FY 2016 Applications

Do not change the site type

20. Site Type (Check all that apply):	Free Enrollment	Reduced Enrollment	Paid Enrollment	Total Enrollment
○ Adult Care Center				0
◉ Child Care Center				
☐ Child Care				0
☐ Head Start Only				0
☑ Outside School Hours			138	138
☐ At-Risk Afterschool Care Center				
☐ Homeless/Emergency Shelter				

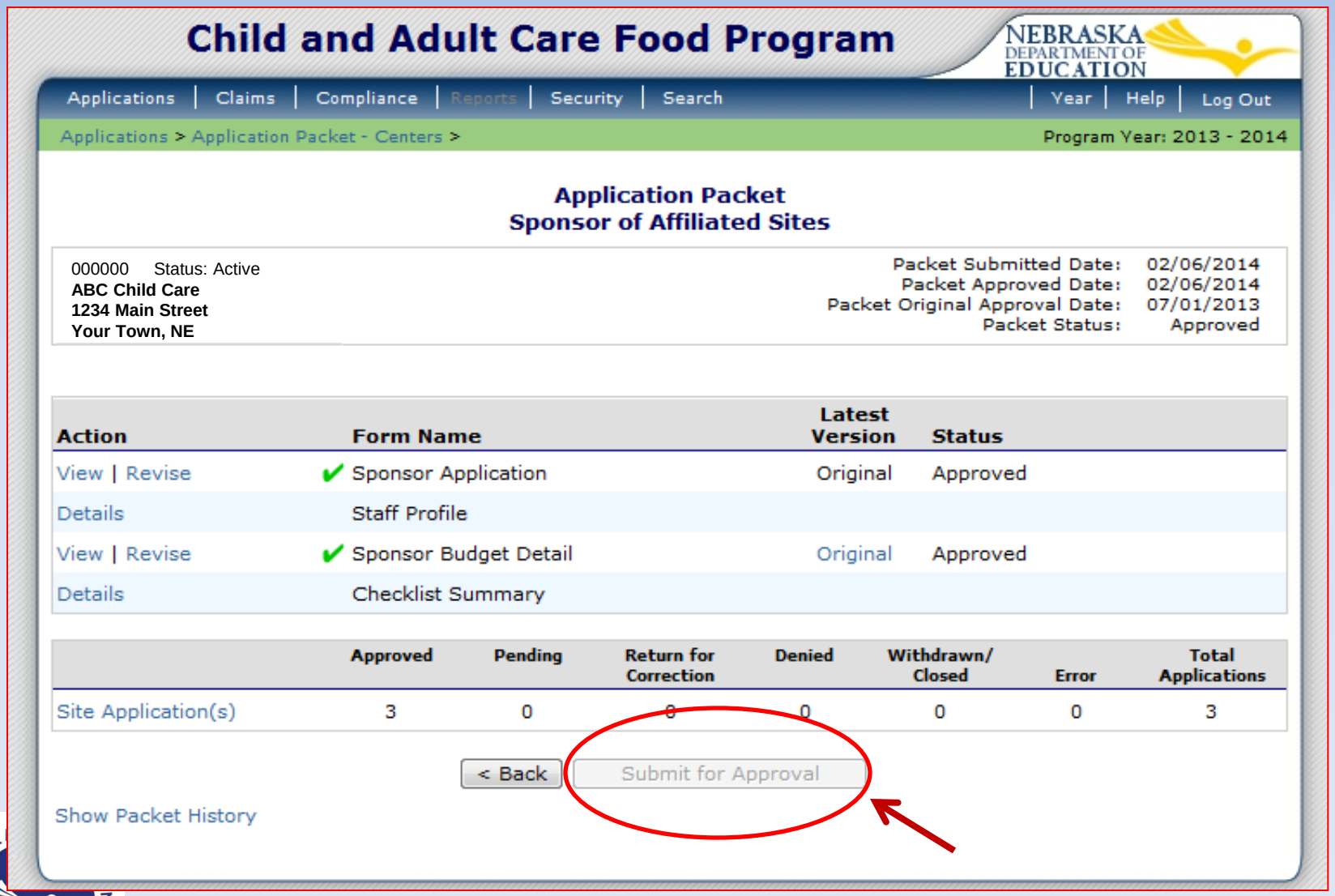
All meals will need to be claimed separately according to the type of program(s) you offer.

- 2 original signature pages on file with NDE – must be checked in checklist summary
- Financial Statement



- Copy of License
- Copy of Child Care Subsidy (Title XX Agreement)

Submit for Approval



Non-profit Food Service

- Must keep ALL receipts for groceries, food service costs, vendor bills. *Remember to check that you are being billed correctly!*
- Must keep valid time certification – must complete bottom portion showing the cost allocated to CACFP.
- Must document how ALL CACFP funds were spent.

Reimbursement

You're receiving money that you SHOULD have already spent on CACFP program costs.

Q: What did NDE just reimburse you for?

A: Receipts and time certifications are for the claiming month; not for expenditure of the following month.

Non-profit Food Service

- CACFP funds are not to be used to fund your payroll expenses.
- *Recommend a minimum of* 50% of your reimbursement is spent on food, groceries, or food service vendors.
- Your business should be paying for general administration, taxes, janitorial services, etc.

CACFP MONTHLY EXPENSES

MONTH/YEAR 3/2015 Page 1 of 1

Check No.	Date	Name of Payee/Vendor	Food	Non food Supplies	Unallowable Costs	Food Service Labor	Admin Labor	Admin Costs	Food Service Equipment	Other		Grand Total
										Description	Amount	
2231	3/1	Big Top Mart	156.09		47.42							203.51
2254	3/11	Big Top Mart		77.81								77.81
Visa	3/28	Big Al's Print						18.06				18.06
2298	3/31	Big Al's Cater	594.00									594.00
	3/31	Sally O'Malley				850.00						850.00
	3/31	Frances Francis				405.00						405.00
	3/31	Jane Doe Crane					373.28					373.28
TOTAL			750.09	77.81	47.42	1255.00	373.28	18.06				2,521.66

Less Unallowable Costs	47.42
Total CACFP	2,474.24

CACFP reimbursement $ 1,400.23 Nonprofit food service? (YES) NO

Percentage of CACFP reimbursement used for food/nonfood supplies $ 59%

$750.09 + $77.81 = $827.90
$827.90 ÷ $1400.23 = 59%

Food Purchases

- MUST get three bids from more than one vendor/grocer
- Includes small purchases from local grocers
  - E.g. Bakers, Walmart, Sam's, Hiland Dairy, Sysco etc.
- Documentation includes:
  - Date
  - Who was contacted
  - Amount quoted – street price in local ads

This is for ALL programs, BIG and small

Handout

INFORMAL PROCUREMENT LOG

Items to be Purchased	Quantity Expected to Buy	Vendor:		Vendor:		Vendor:	
		Unit Price	Extended Price (Quantity x Unit Price)	Unit Price	Extended Price (Quantity x Unit Price)	Unit Price	Extended Price (Quantity x Unit Price)
TOTAL			$		$		$
Vendor Selected		☐		☐		☐	
Date and Method of Contact							
Additional Notes:							
Signature of person completing this form:						Date:	

NEBRASKA DEPARTMENT OF EDUCATION
Nutrition Services

Adapted from Michigan Department of Education

3/19/2014

Financial Viability: Serious Deficiencies

- Failure to pay vendor or your commodity bill

- Failure to document a nonprofit food service


DOOR
PRIZE

Agenda

May Packets/Application Renewals

Record Keeping/Regulations

Crediting Foods/Infant Reminders

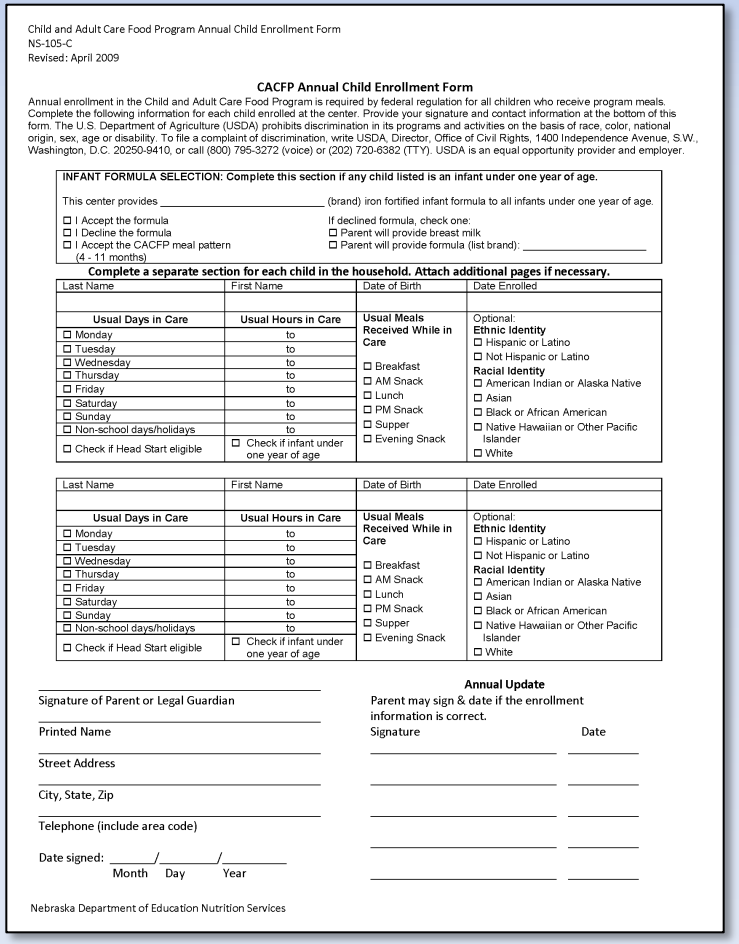
Claiming Meals

- Meals may be claimed only for enrolled participants.
- Over claims are assessed for meals claimed with no enrollment form on file.
- Meals may be claimed only for those served at approved sites and ON SITE.

CACFP Enrollment Forms

Child care centers must have new or updated enrollment forms signed and dated by the parent/guardian on file every 12 months.

Handout



Child and Adult Care Food Program Annual Child Enrollment Form
NS-105-C
Revised: April 2009

CACFP Annual Child Enrollment Form

Annual enrollment in the Child and Adult Care Food Program is required by federal regulation for all children who receive program meals. Complete the following information for each child enrolled at the center. Provide your signature and contact information at the bottom of this form. The U.S. Department of Agriculture (USDA) prohibits discrimination in its programs and activities on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

INFANT FORMULA SELECTION: Complete this section if any child listed is an infant under one year of age.

This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.

☐ I Accept the formula
☐ I Decline the formula
☐ I Accept the CACFP meal pattern (4 - 11 months)

If declined formula, check one:
☐ Parent will provide breast milk
☐ Parent will provide formula (list brand): _____

Complete a separate section for each child in the household. Attach additional pages if necessary.

Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday	to	☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday	to	☐ Lunch	☐ American Indian or Alaska Native
☐ Thursday	to	☐ PM Snack	☐ Asian
☐ Friday	to	☐ Supper	☐ Black or African American
☐ Saturday	to	☐ Evening Snack	☐ Native Hawaiian or Other Pacific Islander
☐ Sunday	to		☐ White
☐ Non-school days/holidays	to		
☐ Check if Head Start eligible	☐ Check if infant under one year of age		

Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday	to	☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday	to	☐ Lunch	☐ American Indian or Alaska Native
☐ Thursday	to	☐ PM Snack	☐ Asian
☐ Friday	to	☐ Supper	☐ Black or African American
☐ Saturday	to	☐ Evening Snack	☐ Native Hawaiian or Other Pacific Islander
☐ Sunday	to		☐ White
☐ Non-school days/holidays	to		
☐ Check if Head Start eligible	☐ Check if infant under one year of age		

_____
Signature of Parent or Legal Guardian

_____
Printed Name

_____
Street Address

_____
City, State, Zip

_____
Telephone (include area code)

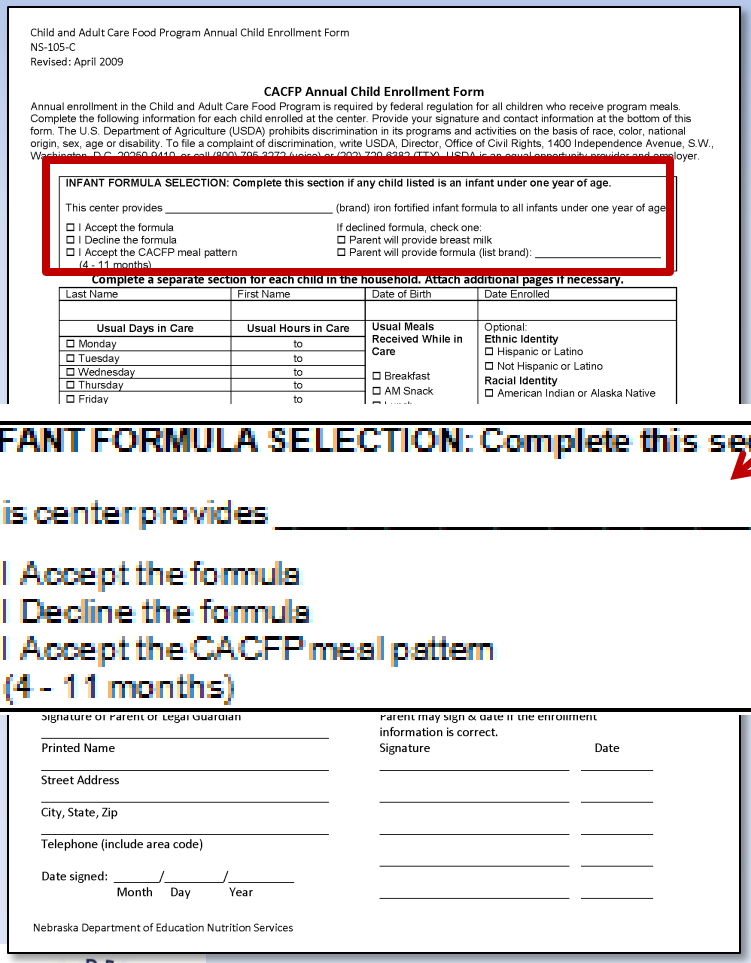
Date signed: _____/_____/_____
Month Day Year

Annual Update
Parent may sign & date if the enrollment information is correct.

Signature	Date

Nebraska Department of Education Nutrition Services

CACFP Enrollment Forms



Child and Adult Care Food Program Annual Child Enrollment Form
NS-105-C
Revised: April 2009

CACFP Annual Child Enrollment Form

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☐ I Accept the formula
☐ I Decline the formula
☐ I Accept the CACFP meal pattern (4 - 11 months)

If declined formula, check one:
☐ Parent will provide breast milk
☐ Parent will provide formula (list brand): _____

Complete a separate section for each child in the household. Attach additional pages if necessary.

Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday	to	☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday	to		☐ American Indian or Alaska Native
☐ Thursday	to		
☐ Friday	to		

Signature of Parent or Legal Guardian

Printed Name

Street Address

City, State, Zip

Telephone (include area code)

Date signed: _____/_____/_____
Month Day Year

Parent may sign & date if the enrollment information is correct.
Signature Date

Nebraska Department of Education Nutrition Services

Complete formula offering before making copies

INFANT FORMULA SELECTION: Complete this section if any child listed is an infant under one year of age.

This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.

☐ I Accept the formula
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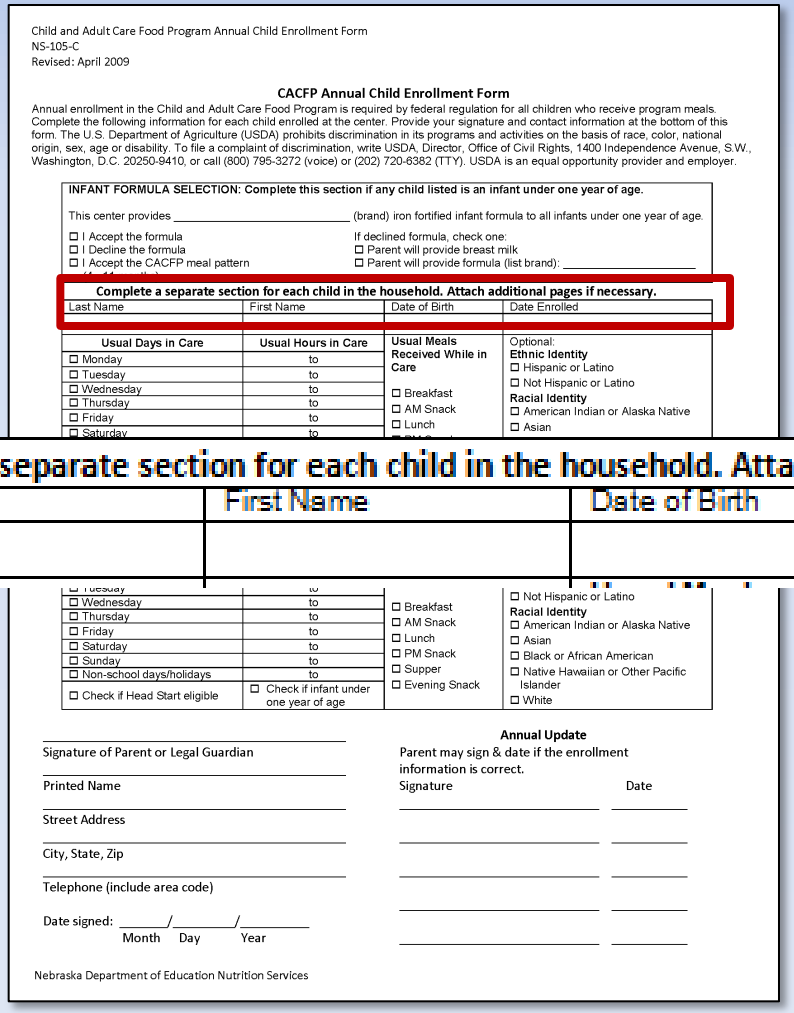
☐ I Accept the CACFP meal pattern (4 - 11 months)

If declined formula, check one:
☐ Parent will provide breast milk
☐ Parent will provide formula (list brand): _____

CACFP Enrollment Forms



Child and Adult Care Food Program Annual Child Enrollment Form
NS-105-C
Revised: April 2009

CACFP Annual Child Enrollment Form

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Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday	to	☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday	to	☐ Lunch	Racial Identity
☐ Thursday	to	☐ PM Snack	☐ American Indian or Alaska Native
☐ Friday	to	☐ Supper	☐ Asian
☐ Saturday	to	☐ Evening Snack	☐ Black or African American
☐ Sunday	to		☐ Native Hawaiian or Other Pacific Islander
☐ Non-school days/holidays	to		☐ White
☐ Check if Head Start eligible	☐ Check if infant under one year of age		

Signature of Parent or Legal Guardian

Printed Name

Street Address

City, State, Zip

Telephone (include area code)

Date signed: _____/_____/_____
Month Day Year

Annual Update

Parent may sign & date if the enrollment information is correct.

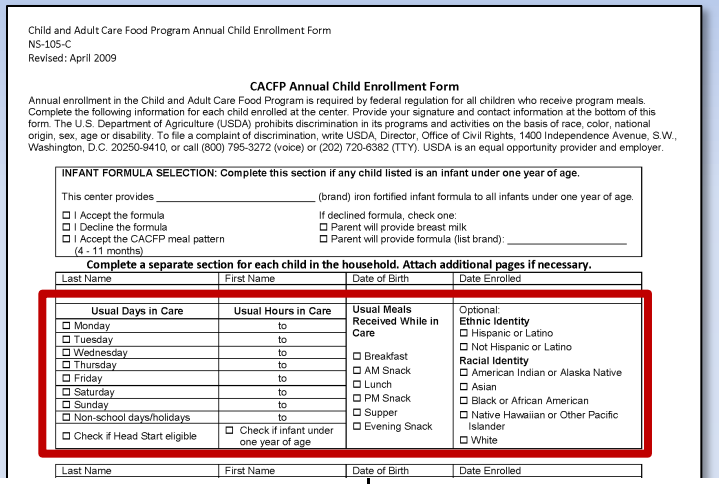
Signature Date

Nebraska Department of Education Nutrition Services

Complete a separate section for each child in the household. Attach additional pages if necessary.

Last Name | First Name | Date of Birth | Date Enrolled

CACFP Enrollment Forms



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If declined formula, check one:
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☐ Parent will provide formula (list brand): _____

Complete a separate section for each child in the household. Attach additional pages if necessary.

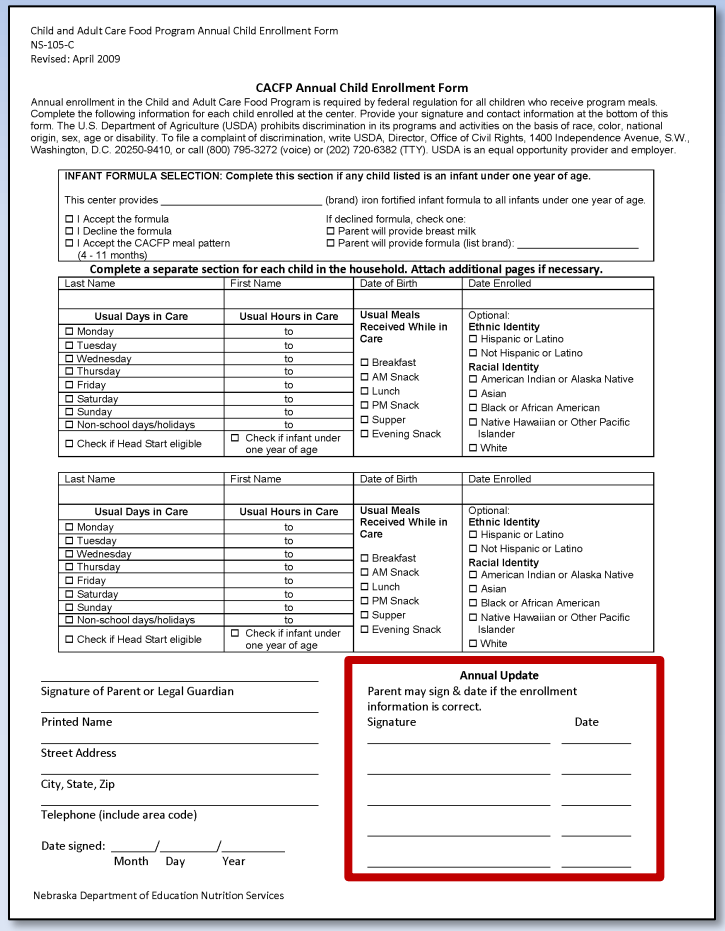
Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	Ethnic Identity
☐ Tuesday	to	☐ AM Snack	☐ Hispanic or Latino
☐ Wednesday	to	☐ Lunch	☐ Not Hispanic or Latino
☐ Thursday	to	☐ PM Snack	Racial Identity
☐ Friday	to	☐ Supper	☐ American Indian or Alaska Native
☐ Saturday	to	☐ Evening Snack	☐ Asian
☐ Sunday	to		☐ Black or African American
☐ Non-school days/holidays	to		☐ Native Hawaiian or Other Pacific Islander
☐ Check if Head Start eligible	☐ Check if infant under one year of age		☐ White

Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	Ethnic Identity
☐ Tuesday	to	☐ AM Snack	☐ Hispanic or Latino
☐ Wednesday	to	☐ Lunch	☐ Not Hispanic or Latino
☐ Thursday	to	☐ PM Snack	Racial Identity
☐ Friday	to	☐ Supper	☐ American Indian or Alaska Native
☐ Saturday	to	☐ Evening Snack	☐ Asian
☐ Sunday	to		☐ Black or African American
☐ Non-school days/holidays	to		☐ Native Hawaiian or Other Pacific Islander
☐ Check if Head Start eligible	☐ Check if infant under one year of age		☐ White

CACFP Enrollment Forms



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NS-105-C
Revised: April 2009

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☐ I Decline the formula
☐ I Accept the CACFP meal pattern (4 - 11 months)

If declined formula, check one:
☐ Parent will provide breast milk
☐ Parent will provide formula (list brand): _____

Complete a separate section for each child in the household. Attach additional pages if necessary.

Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday	to	☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday	to	☐ Lunch	☐ American Indian or Alaska Native
☐ Thursday	to	☐ PM Snack	☐ Asian
☐ Friday	to	☐ Supper	☐ Black or African American
☐ Saturday	to	☐ Evening Snack	☐ Native Hawaiian or Other Pacific Islander
☐ Sunday	to		☐ White
☐ Non-school days/holidays	to		
☐ Check if Head Start eligible	☐ Check if infant under one year of age		

Last Name	First Name	Date of Birth	Date Enrolled

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday	to	☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday	to	☐ Lunch	☐ American Indian or Alaska Native
☐ Thursday	to	☐ PM Snack	☐ Asian
☐ Friday	to	☐ Supper	☐ Black or African American
☐ Saturday	to	☐ Evening Snack	☐ Native Hawaiian or Other Pacific Islander
☐ Sunday	to		☐ White
☐ Non-school days/holidays	to		
☐ Check if Head Start eligible	☐ Check if infant under one year of age		

_____
Signature of Parent or Legal Guardian

_____
Printed Name

_____
Street Address

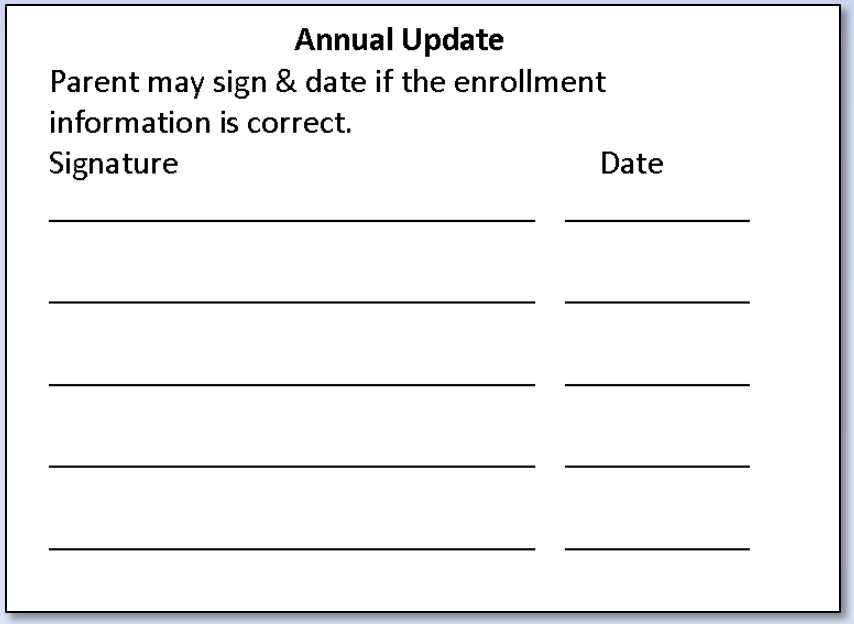
_____
City, State, Zip

_____
Telephone (include area code)

Date signed: _____/_____/_____
Month Day Year

Annual Update
Parent may sign & date if the enrollment information is correct.
Signature Date

Nebraska Department of Education Nutrition Services



Annual Update

Parent may sign & date if the enrollment information is correct.

Signature Date

Every year!

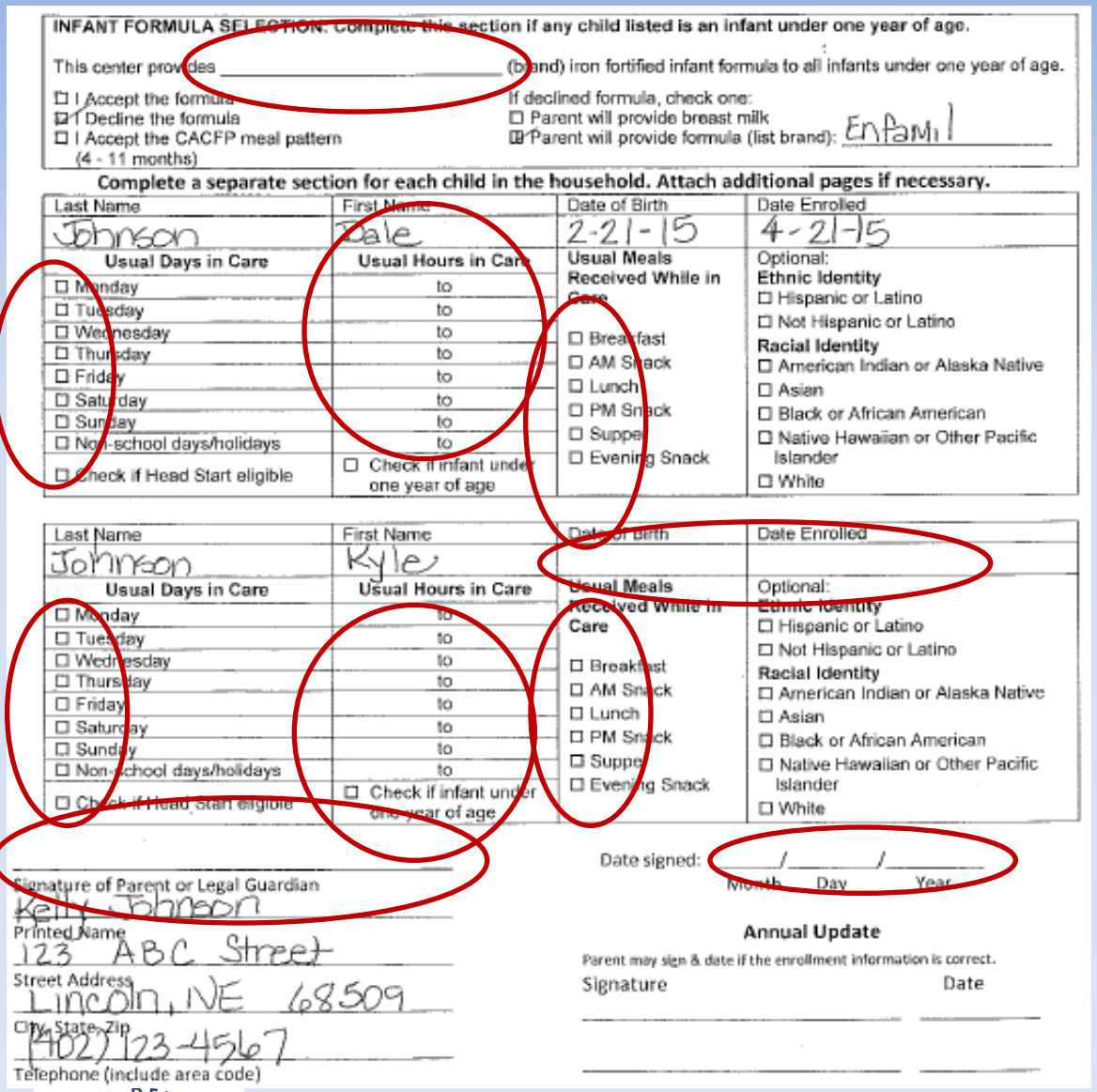
Nebraska Department of Education Nutrition Services CACFP Spring 2015

CACFP Enrollment Forms

- Don’t assume the parent has completed the enrollment form
- Provider’s responsibility to ensure all info is collected:
  - Name
  - Date of birth
  - Date enrolled
  - Signature of parent/guardian
  - Days and times in care (child care only)
  - Usual meals served in care (child care only)

CACFP Enrollment Forms

- Recommend updating enrollments during June-July
- Don’t forget families on vacation
- Must update child enrollment forms annually for all children
- Good for one year
  Example: July 1, 2015 – July 31, 2016



INFANT FORMULA SELECTION: Complete this section if any child listed is an infant under one year of age.

This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.

☐ I Accept the formula
☑ I Decline the formula
☐ I Accept the CACFP meal pattern (4 - 11 months)

If declined formula, check one:
☐ Parent will provide breast milk
☑ Parent will provide formula (list brand): EnFamil

Complete a separate section for each child in the household. Attach additional pages if necessary.

Last Name	First Name	Date of Birth	Date Enrolled
Johnson	Dale	2-21-15	4-21-15

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday	to	☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday	to	☐ Lunch	☐ American Indian or Alaska Native
☐ Thursday	to	☐ PM Snack	☐ Asian
☐ Friday	to	☐ Supper	☐ Black or African American
☐ Saturday	to	☐ Evening Snack	☐ Native Hawaiian or Other Pacific Islander
☐ Sunday	to		☐ White
☐ Non-school days/holidays	to		
☐ Check if Head Start eligible	☐ Check if infant under one year of age		

Last Name	First Name	Date of Birth	Date Enrolled
Johnson	Kyle		

Usual Days in Care	Usual Hours in Care	Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday	to	☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday	to	☐ Lunch	☐ American Indian or Alaska Native
☐ Thursday	to	☐ PM Snack	☐ Asian
☐ Friday	to	☐ Supper	☐ Black or African American
☐ Saturday	to	☐ Evening Snack	☐ Native Hawaiian or Other Pacific Islander
☐ Sunday	to		☐ White
☐ Non-school days/holidays	to		
☐ Check if Head Start eligible	☐ Check if infant under one year of age		

Signature of Parent or Legal Guardian: Keith Johnson

Printed Name

123 ABC Street
Street Address

Lincoln, NE 68509
City, State, Zip

(402) 123-4567
Telephone (include area code)

Date signed: ___/___/___
Month Day Year

Annual Update

Parent may sign & date if the enrollment information is correct.

Signature _____ Date _____

_____ _____

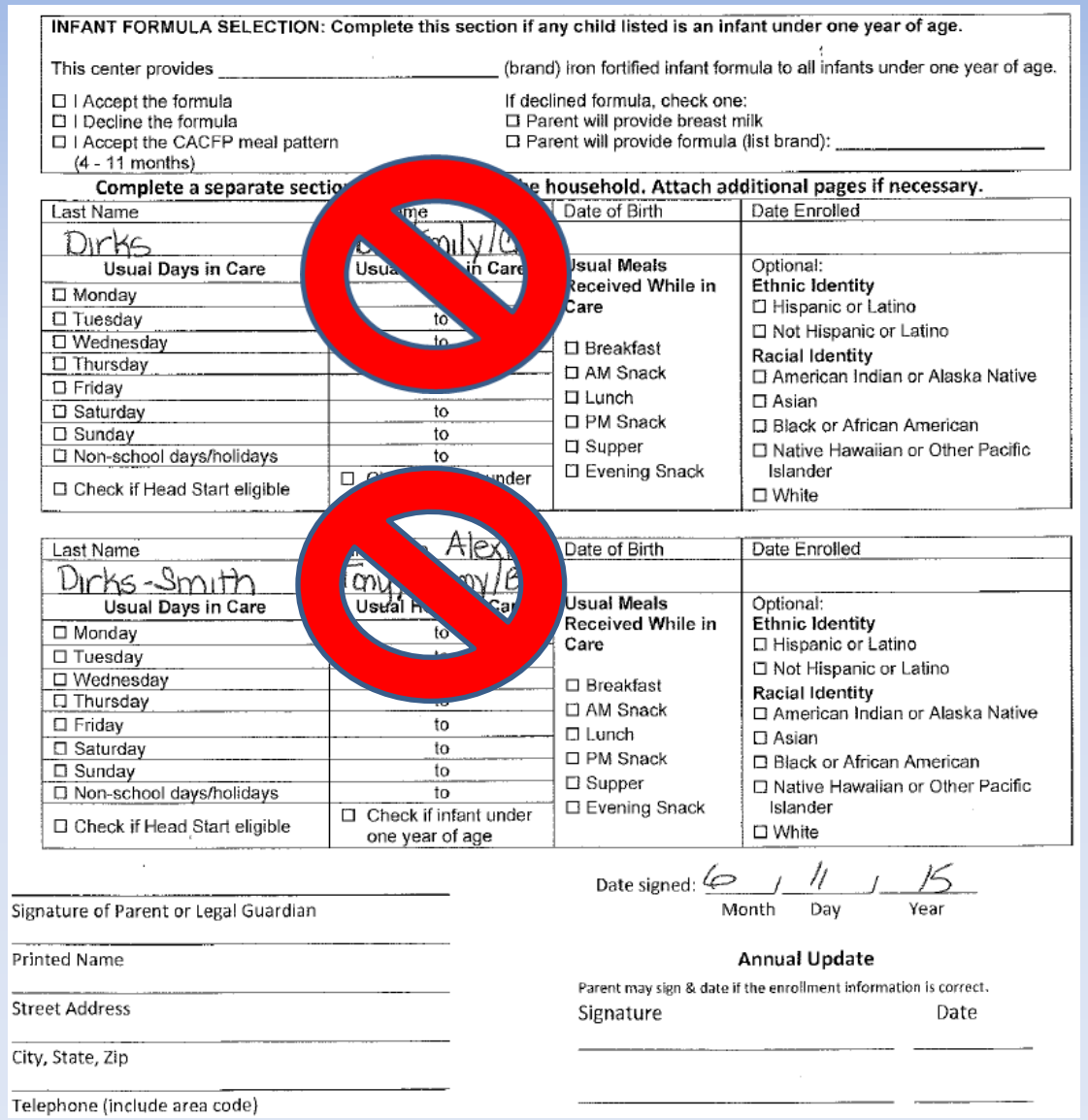
Is this complete?

What's missing?

Page 1

One child per line.

Use provided addendum from May packets.



INFANT FORMULA SELECTION: Complete this section if any child listed is an infant under one year of age.

This center provides _____ (brand) iron fortified infant formula to all infants under one year of age.

- ☐ I Accept the formula
- ☐ I Decline the formula
- ☐ I Accept the CACFP meal pattern (4 - 11 months)

If declined formula, check one:
- ☐ Parent will provide breast milk
- ☐ Parent will provide formula (list brand): _____

Complete a separate sectio… household. Attach additional pages if necessary.

Last Name	Date of Birth	Date Enrolled
Dirks		

Usual Days in Care		Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday	to	☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday	to	☐ Lunch	☐ American Indian or Alaska Native
☐ Thursday		☐ PM Snack	☐ Asian
☐ Friday		☐ Supper	☐ Black or African American
☐ Saturday	to	☐ Evening Snack	☐ Native Hawaiian or Other Pacific Islander
☐ Sunday	to		☐ White
☐ Non-school days/holidays	to		
☐ Check if Head Start eligible	☐ …nder		

Last Name	Date of Birth	Date Enrolled
Dirks-Smith		

Usual Days in Care		Usual Meals Received While in Care	Optional: Ethnic Identity / Racial Identity
☐ Monday	to	☐ Breakfast	☐ Hispanic or Latino
☐ Tuesday		☐ AM Snack	☐ Not Hispanic or Latino
☐ Wednesday		☐ Lunch	☐ American Indian or Alaska Native
☐ Thursday		☐ PM Snack	☐ Asian
☐ Friday	to	☐ Supper	☐ Black or African American
☐ Saturday	to	☐ Evening Snack	☐ Native Hawaiian or Other Pacific Islander
☐ Sunday	to		☐ White
☐ Non-school days/holidays	to		
☐ Check if Head Start eligible	☐ Check if infant under one year of age		

Signature of Parent or Legal Guardian

Printed Name

Street Address

City, State, Zip

Telephone (include area code)

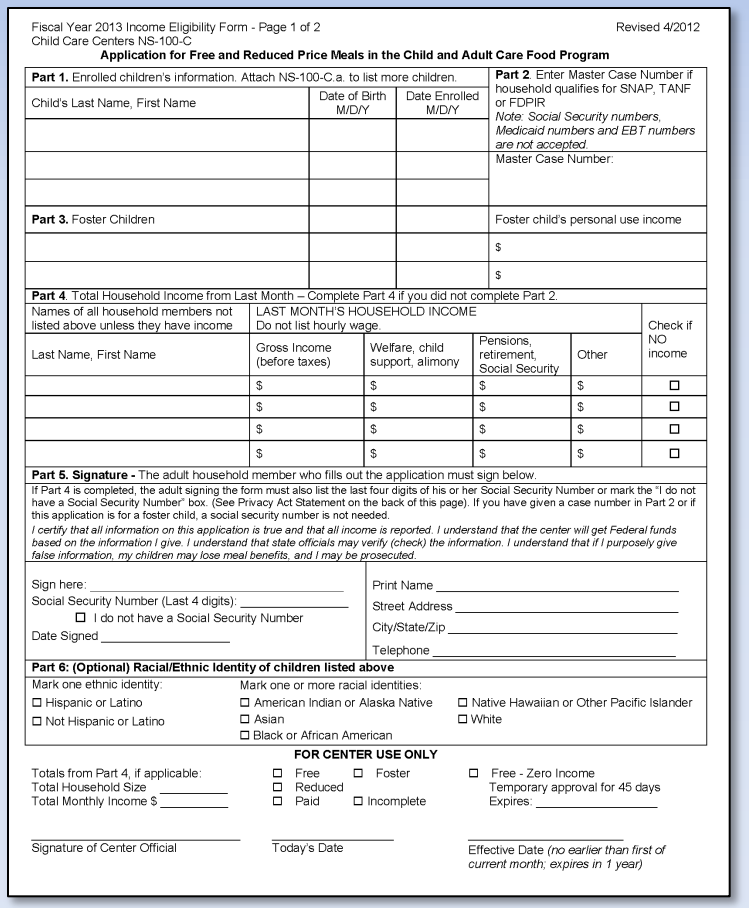
Date signed: 6 / 11 / 15
Month Day Year

Annual Update

Parent may sign & date if the enrollment information is correct.

Signature Date

Income Eligibility Forms



Fiscal Year 2013 Income Eligibility Form - Page 1 of 2 Revised 4/2012
Child Care Centers NS-100-C

Application for Free and Reduced Price Meals in the Child and Adult Care Food Program

Part 1. Enrolled children's information. Attach NS-100-C.a. to list more children.

Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y
Part 3. Foster Children		

Part 2. Enter Master Case Number if household qualifies for SNAP, TANF or FDPIR
Note: Social Security numbers, Medicaid numbers and EBT numbers are not accepted.
Master Case Number:

Foster child's personal use income
$
$

Part 4. Total Household Income from Last Month – Complete Part 4 if you did not complete Part 2.

Names of all household members not listed above unless they have income	LAST MONTH'S HOUSEHOLD INCOME Do not list hourly wage.				Check if NO income
Last Name, First Name	Gross Income (before taxes)	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
	$	$	$	$	☐
	$	$	$	$	☐
	$	$	$	$	☐
	$	$	$	$	☐

Part 5. Signature - The adult household member who fills out the application must sign below.

If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page). If you have given a case number in Part 2 or if this application is for a foster child, a social security number is not needed.

I certify that all information on this application is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that state officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: _____
Social Security Number (Last 4 digits): _____
☐ I do not have a Social Security Number
Date Signed _____

Print Name _____
Street Address _____
City/State/Zip _____
Telephone _____

Part 6: (Optional) Racial/Ethnic Identity of children listed above

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

FOR CENTER USE ONLY

Totals from Part 4, if applicable:
Total Household Size _____
Total Monthly Income $ _____

☐ Free ☐ Foster
☐ Reduced
☐ Paid ☐ Incomplete

☐ Free - Zero Income
Temporary approval for 45 days
Expires: _____

_____ Signature of Center Official

_____ Today's Date

_____ Effective Date *(no earlier than first of current month; expires in 1 year)*

- IEFs **REQUIRED** to be new EVERY year
- No updating
- It's like filing taxes – incomes change

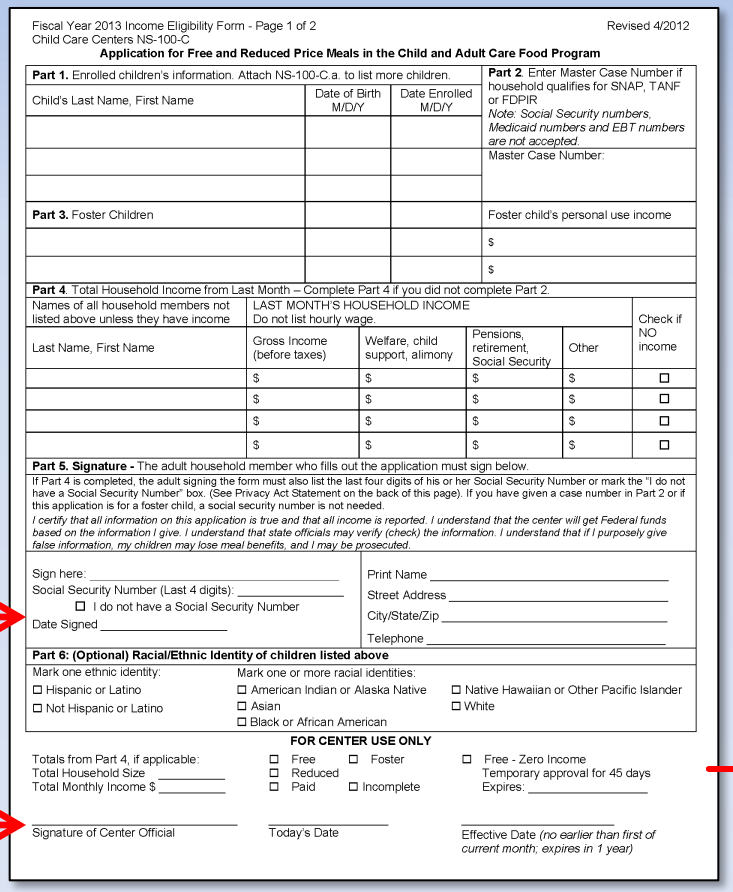
DO NOT update!

Income Eligibility Forms

- NEVER OKAY to forge a parent's/guardian's signature or household income

- Do not assume household categorical benefits apply based on Child Care Subsidy (Title XX)

Income Eligibility Forms



Fiscal Year 2013 Income Eligibility Form - Page 1 of 2 — Revised 4/2012
Child Care Centers NS-100-C

Application for Free and Reduced Price Meals in the Child and Adult Care Food Program

Part 1. Enrolled children's information. Attach NS-100-C.a. to list more children.

Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y
Part 3. Foster Children		

Part 2. Enter Master Case Number if household qualifies for SNAP, TANF or FDPIR
Note: Social Security numbers, Medicaid numbers and EBT numbers are not accepted.
Master Case Number:

Foster child's personal use income
$
$

Part 4. Total Household Income from Last Month – Complete Part 4 if you did not complete Part 2.

Names of all household members not listed above unless they have income	LAST MONTH'S HOUSEHOLD INCOME Do not list hourly wage.				Check if NO income
Last Name, First Name	Gross Income (before taxes)	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
	$	$	$	$	☐
	$	$	$	$	☐
	$	$	$	$	☐
	$	$	$	$	☐

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I certify that all information on this application is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that state officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: _____
Social Security Number (Last 4 digits): _____
☐ I do not have a Social Security Number
Date Signed _____

Print Name _____
Street Address _____
City/State/Zip _____
Telephone _____

Part 6: (Optional) Racial/Ethnic Identity of children listed above

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

FOR CENTER USE ONLY

Totals from Part 4, if applicable:
Total Household Size _____
Total Monthly Income $ _____

☐ Free ☐ Foster
☐ Reduced
☐ Paid ☐ Incomplete

☐ Free - Zero Income
Temporary approval for 45 days
Expires: _____

_____ Signature of Center Official

_____ Today's Date

_____ Effective Date *(no earlier than first of current month; expires in 1 year)*

- NDE recommends obtaining **new** IEFs in June or July to be effective July 1 instead of waiting until the month they expire
- SIGN, DETERMINE and DATE every IEF within 10 days of receipt
- IEF is incomplete without signatures and determination

Income Eligibility Forms:

Parts 1 and 2

Name and Case Number

Part 1. Enrolled children's information. Attach NS-100-C.a. to list more children.			**Part 2.** Enter Master Case Number if household qualifies for SNAP, TANF or FDPIR *Note: Social Security numbers, Medicaid numbers and EBT numbers are not accepted.*
Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y	
Rodriguez , Daniel (D.J.)			
			Master Case Number: 00112233
Part 3. Foster Children			Foster child's personal use income
			$
			$

Parents/guardians need to indicate which benefit they receive.

Make no assumptions!

IEF: Case Numbers

- Circle the qualifying benefit: SNAP, TANF, FDPIR
- Social Security Numbers NOT valid so don't accept them
  - Social Security Numbers are associated only with adult centers' Medicaid recipients

Income Eligibility Forms

- Full names of participants
- Do not pre-sign or pre-date IEFs
- Child Care Subsidy (Title XX) authorization does not equal Free status.
- Do not make assumptions or alter information provided; NO WHITE OUT
  - Strike out and initial errors

Foster Children

- Foster children do not need their own IEF – Part 3
- MUST list personal use income (or $0 if none)
- Part 2 if appropriate

Part 1. Enrolled children's information. Attach NS-100-C.a. to list more children.			**Part 2.** Enter Master Case Number if household qualifies for SNAP, TANF or FDPIR *Note: Social Security numbers, Medicaid numbers and EBT numbers are not accepted.*
Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y	
Rodriguez , Daniel (D.J.)	**4/6/09**		
			Master Case Number: **00112233**
Part 3. Foster Children			Foster child's personal use income
Garber, Cyrus			$ **$0**
			$

IEF: Foster Children

- Households may include foster children on IEF to increase household size.
- Other children in household classified based on total household size, including foster children, and all household income received.
- Money received for caring for foster child(ren) is not counted as income.

Income Eligibility Forms:
Parts 4 & 5
Household members, income & signature

- Zero Income forms are <u>good for one year</u>

- An IEF without income documented is incomplete and qualifies for PAID meals

Income Eligibility Forms:

Parts 4 & 5

Household members, income & signature

Names of all household members not listed above unless they have income	LAST MONTH'S HOUSEHOLD INCOME Do not list hourly wage.				Check if NO income
Last Name, First Name	Gross Income (before taxes)	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
	$	$	$		☐
Jane Doe	$	$			☐
Jethro Doe	$	$			☐
	$	$	$	$	☐

Incomplete

Names of all household members not listed above unless they have income	LAST MONTH'S HOUSEHOLD INCOME Do not list hourly wage.				Check if NO income
Last Name, First Name	Gross Income (before taxes)	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
Jane Doe	$ 0	$	$	$	☐
Jethro Doe	$	$	$	$	☒
	$	$	$	$	☐
	$	$	$	$	☐

Income Eligibility Forms

- Need a **NEW** IEF every 12 months
  - expire on a calendar year basis
- Effective through the *end of the month of determination*
- Example:
  - IEF effective April 1, 2015
  - Expires April 30, 2016

Must get new IEF each year!

Income Eligibility Forms

- Effective date can be backdated to the *previous month* if parent signature is within previous month

AND

- Program must inform NDE how effective dates will be determined with written statement of procedures
- Must be consistent; use same method with all participants

**see USDA memo dated Oct. 31, 2014*

(handout)

Do not update forms

Parent signed June 2015; baby added October 2015.

A: **NO**

Fiscal Year 2015 Income Eligibility Form - Page 1 of 2 — Revised 4/2014
Child Care Centers NS-100-C

Application for Free and Reduced Price Meals in the Child and Adult Care Food Program

Part 1. Enrolled children's information. Attach NS-100-C.a. to list more children.

Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y
Hall, Jenny	6-14-13	
Hall, Alex	10-20-10	
Hall, Samantha	10-1-15	

Part 2. Enter Master Case Number if household qualifies for SNAP, TANF or FDPIR
Note: Social Security numbers, Medicaid numbers and EBT numbers are not accepted.
Master Case Number:

Part 3. Foster Children — Foster child's personal use income

	$
	$

Part 4. Total Household Income from Last Month – Complete Part 4 if you did not complete Part 2.

Names of all household members not listed above unless they have income	LAST MONTH'S HOUSEHOLD INCOME Do not list hourly wage.				Check if NO income
Last Name, First Name	Gross Income (before taxes)	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
Hall, Katrina	$	$	$	$	☐
	$	$	$	$	☐
	$	$	$	$	☐
	$	$	$	$	☐

Part 5. Signature - The adult household member who fills out the application must sign below.
If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page). If you have given a case number in Part 2 or if this application is for a foster child, a social security number is not needed.
I certify that all information on this application is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that state officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: Katrina Hall
Social Security Number (Last 4 digits): _____
☐ I do not have a Social Security Number
Date Signed 6/1/15

Print Name _____
Street Address _____
City/State/Zip _____
Telephone _____

Part 6: (Optional) Racial/Ethnic Identity of children listed above

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

FOR CENTER USE ONLY

Totals from Part 4, if applicable:
Total Household Size _____
Total Monthly Income $ _____

☑ Free ☐ Reduced ☐ Paid ☐ Foster ☐ Incomplete

Abbygail Smith
Signature of Center Official

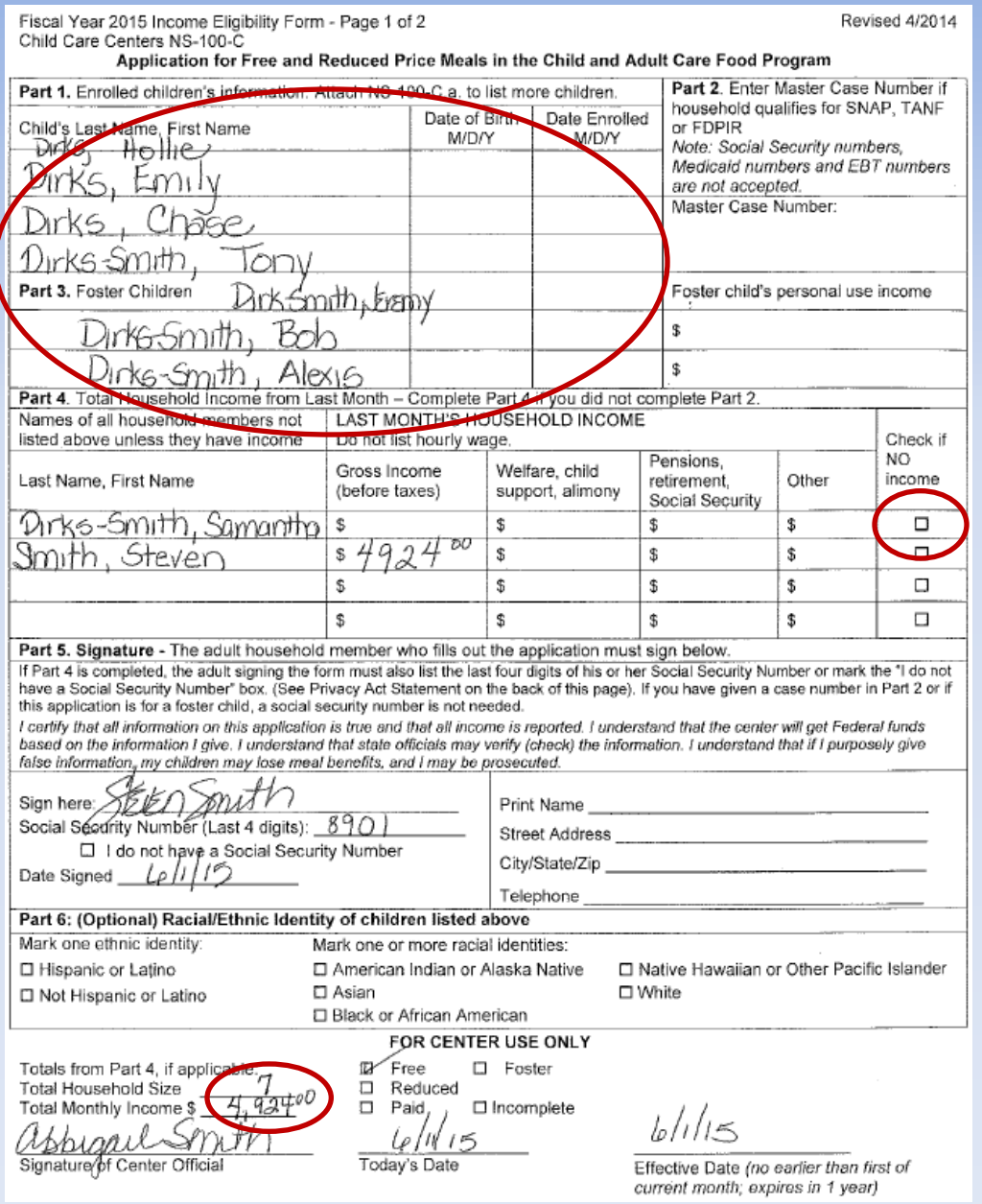
6/1/15
Today's Date

6/1/15
Effective Date *(no earlier than first of current month; expires in 1 year)*

Are these foster children?

Does Samantha have income?

Household size?



Fiscal Year 2015 Income Eligibility Form - Page 1 of 2 — Revised 4/2014
Child Care Centers NS-100-C

Application for Free and Reduced Price Meals in the Child and Adult Care Food Program

Part 1. Enrolled children's information. Attach NS-100-C a. to list more children.

Child's Last Name, First Name	Date of Birth M/D/Y	Date Enrolled M/D/Y
Dirks, Hollie		
Dirks, Emily		
Dirks, Chase		
Dirks-Smith, Tony		
Part 3. Foster Children Dirk Smith, Jenny		
Dirks-Smith, Bob		
Dirks-Smith, Alexis		

Part 2. Enter Master Case Number if household qualifies for SNAP, TANF or FDPIR
Note: Social Security numbers, Medicaid numbers and EBT numbers are not accepted.
Master Case Number:

Foster child's personal use income
$
$

Part 4. Total Household Income from Last Month – Complete Part 4 if you did not complete Part 2.

Names of all household members not listed above unless they have income. Last Name, First Name	LAST MONTH'S HOUSEHOLD INCOME Do not list hourly wage. Gross Income (before taxes)	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	Check if NO income
Dirks-Smith, Samantha	$	$	$	$	☐
Smith, Steven	$ 4924.00	$	$	$	☐
	$	$	$	$	☐
	$	$	$	$	☐

Part 5. Signature - The adult household member who fills out the application must sign below.
If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page). If you have given a case number in Part 2 or if this application is for a foster child, a social security number is not needed.
I certify that all information on this application is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that state officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: Steven Smith
Social Security Number (Last 4 digits): 8901
☐ I do not have a Social Security Number
Date Signed 6/1/15

Print Name
Street Address
City/State/Zip
Telephone

Part 6: (Optional) Racial/Ethnic Identity of children listed above

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

FOR CENTER USE ONLY

Totals from Part 4, if applicable:
Total Household Size 7
Total Monthly Income $ 4,924.00

☑ Free ☐ Foster
☐ Reduced
☐ Paid ☐ Incomplete

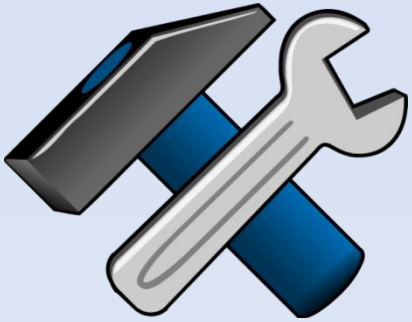
Abbigail Smith
Signature of Center Official

6/11/15
Today's Date

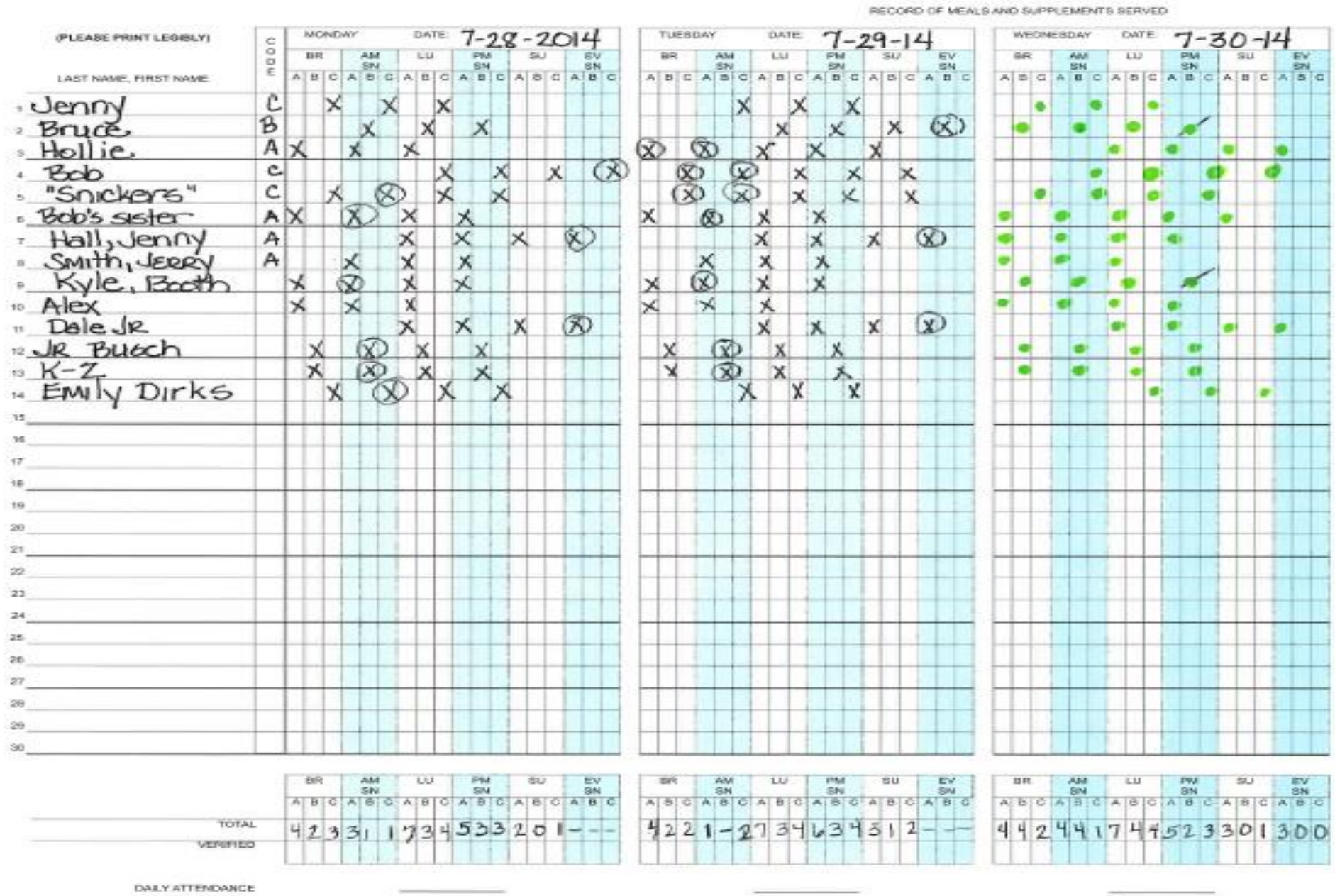
6/1/15
Effective Date *(no earlier than first of current month; expires in 1 year)*

Meal Counts

- Enter Full Name – Last Name, First Name
- Record date – month, day, year
- Meal counts done **ONLY** at the time of the meal service while children at the table
- Maximum 3 meals/child each day
  - 2 main meals + 1 snack
  - 1 main meal + 2 snacks
  - 4th meals must NOT BE CLAIMED



Handout


RECORD OF MEALS AND SUPPLEMENTS SERVED
(PLEASE PRINT LEGIBLY)
LAST NAME, FIRST NAME
CODE
MONDAY DATE: 7-28-2014
TUESDAY DATE: 7-29-14
WEDNESDAY DATE: 7-30-14
BR
AM SN
LU
PM SN
SU
EV SN
A B C
1 Jenny C
2 Bruce B
3 Hollie A
4 Bob C
5 "Snickers" C
6 Bob's sister A
7 Hall, Jenny A
8 Smith, Jeery A
9 Kyle, Booth
10 Alex
11 Dale JR
12 JR Busch
13 K-Z
14 Emily Dirks
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
TOTAL
VERIFIED
4 2 3 3 1 1 7 3 4 5 3 3 2 0 1 - - -
4 2 2 1 - 2 7 3 4 6 3 4 3 1 2 - - -
4 4 2 4 4 1 7 4 4 5 2 3 3 0 1 3 0 0
DAILY ATTENDANCE

WIC Information

- CACFP child care centers are required to distribute information about WIC to enrolled families.
- This does not apply to Outside-school hour programs or Adult programs.
- See WIC flyer in May packet.

Record Retention

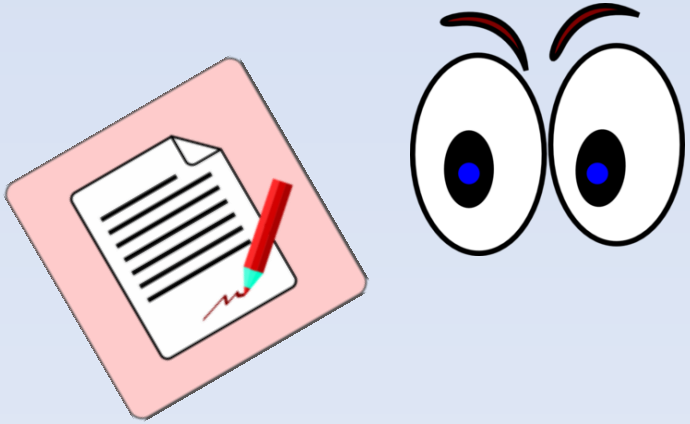
- All records must be **COMPLETE** and on site for the current year. (Hard copy or electronic)
- Deductions *will be made* if the last 12 months of records are not on-site.
- Off-site storage? Must be stated on the application.
- Keep for 3 years after submission of the final claim for the fiscal year.

Records to Keep

- Claims
- Claim worksheets
- Enrollment forms
- Income eligibility forms
- Meal count sheets
- Meal production records (regular & infant)
- Receipts for expenditures
- Attendance records (times in/out)

Attendance Records

- NDE will be comparing your time-in and time-out records against your child care subsidy attendance records
- Any discrepancies will be reported to the appropriate DHHS officials



Record Keeping in At-Risk Afterschool

- After-school snacks & suppers in low-income areas for school-age children
- Approved site
  - Determination by NDE staff only
- At-risk meals/snacks claimed ONLY during school year AFTER school and on non-school days
- Facility must provide an enrichment/educational activity for all children in attendance

**See At-risk Handbook p. 15 for further clarification of eligibility*

Record Keeping in At-Risk Afterschool

- Track at-risk meals/snacks separately from regular meals/snacks – different Blue & White sheets
- Meal counts must be completed **DAILY** for each meal service
- **DAILY** attendance or **DAILY** roster
- Daily production records

**At-risk guidance booklet

At-Risk Afterschool Meals

- Do not enter “regular” meals in the At-risk section of the claim

Regular Meals Served Only (Do not include At-Risk Meals)				
Meal Type	Free Meals (A)	Reduced Meals (B)	Paid Meals (C)	Total Meals (A+B+C)
Regular Breakfasts				0
Regular A.M. Snacks				0
Regular Lunches				0
Regular P.M. Snacks				0
Regular Supper				0
Regular Evening Snack				0

At-Risk Meals Only (Meals claimed At-Risk cannot be claimed above in Regular Meals) Do not include any meals that are claimed above. Breakfasts and Lunches may be claimed only on school’s out days, vacation days (e.g., winter and springs break) and weekends during the school year.				
Meal Type	Number Days Served	Number of At-Risk Participants	Average Daily Attendance	Meals Served
At-Risk Breakfasts				
At-Risk A.M. Snacks				
At-Risk Lunches				
At-Risk P.M. Snacks				
At-Risk Supper				
At-Risk Evening Snack				

NDE's typical drop-in visits

- **Meal production** records completed through most current meal OR delivery tickets from vendor
- **Meal count** records that are up-to-date
- **Time in/Time out** attendance records
- **Infant production** records through most current meal
- **Income Eligibility Forms** are in secure location
- View how and where old records are stored
- Complaint visits may require more in-depth investigation

Corrective Action Plans

- Reasons for CAP
  - 10% finding error (production records, IEFs, enrollments, infant records)
  - Failing to meet non-profit food service status
  - Purchasing poor-quality foods; non-compliant meals
  - Not following management plan/application (staff training, site visits)
  - Failure to meet deadlines
  - Repeated findings from previous reviews

Not an all-inclusive list!

Corrective Action Plans

- When corrective action is required:
  - Written documentation
    - What: identify the finding(s)
    - When: provide timeline for implementing procedure for correction
    - Where: will the CAP be retained?
    - How: will staff and facilities be informed of new policies, procedures?
      - Handbooks, trainings, etc.
    - Who: personnel responsible for correcting the findings

CAP Handout

Agreement # _____
Organization Name/Address:
_____
_____
_____

NEBRASKA DEPARTMENT OF EDUCATION

Nutrition Services, Child and Adult Care Food Program (CACFP)

Page _____ of _____
Due Date: _____

CORRECTIVE ACTION PLAN

WHAT		WHO	WHEN	WHERE	HOW	DATE
Finding Item #	Correct Action	Individual Responsible	Frequency	Location of CAP Documentation	Method of Implementation	Date of implementation

Corrective Action Plans

- Fail to comply with CAP?
  - May be declared *Seriously Deficient*
- Records are STILL not in compliance after serious deficiency determination?
  - *Termination*
  - *Placement on the National Disqualified List*
  - *Pay back reimbursement* for period of missing records

Food Service Contracts

- Documentation: *complete and submit Attachment A & B*
  - Type of procurement
  - Name all vendors contacted, the amount of each bid & the date of each bid
  - Can renew contract 4 times (after 5 years must receive new bids)
  - Contracts over $50,000 must be approved by NDE prior to being signed by program

Food Service Contracts

- Pay your vendor according to contract
- Ensure delivery slips are complete
  - Dates, food quantity & components
  - CN labels & recipes available upon request
- Must notify NDE if you switch from self-prep to a vendor or vise versa.
  - Revise your online application
  - Notify in writing (fax, email, letter)

Civil Rights

Centers are required to:

- Collect racial and ethnic information
- Submit racial and ethnic data.
- Report aggregate data on their application each year
- Provide Civil Rights training to staff

For further information refer to NDE website:
www.education.ne.gov/ns

Civil Rights

- If a participant is biracial or multi-racial, they may mark all applicable categories.
- When compiling data, these participants are counted in each of the categories.
- Aggregate totals may be more than your total enrollment.
- Programs are responsible to provide information of Civil Rights to families.

Civil Rights

You may not deny program services or separate participants in these categories: (handout March 20, 2015)

- Race
- Color
- National Origin
- Sex
- Age
- Disability

And Justice for All

This poster must be displayed in each center.

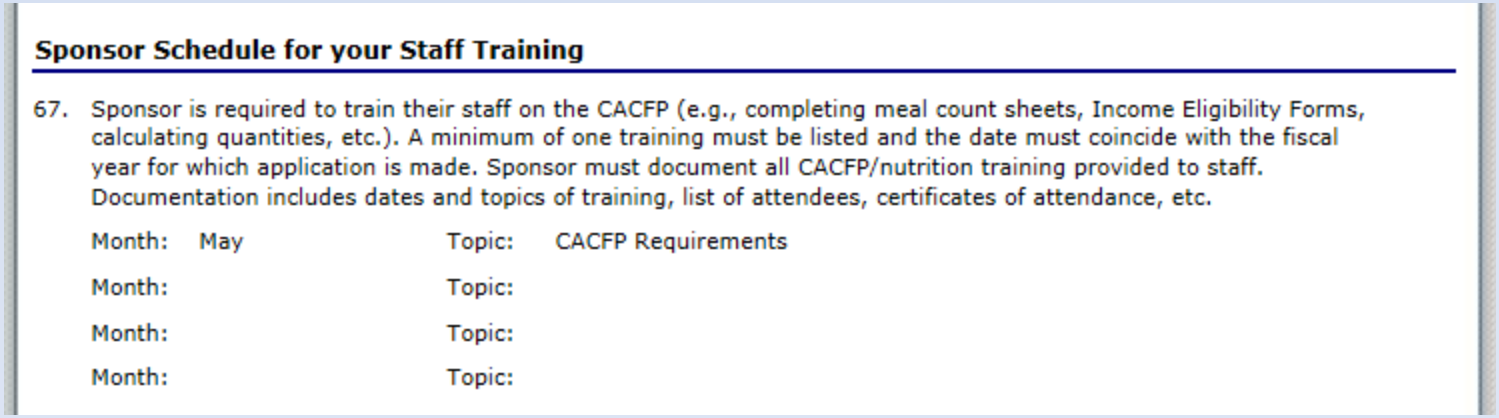
If you have anything ***other*** than this, take it down.

Participant Privacy

- Do not email documents with confidential information
  - DOB, social security number, etc.
- Ask NDE Staff for guidance

Management Plans: Staff Training

- You **must** train your staff on CACFP requirements
- Follow the management plan **YOU** made



Sponsor Schedule for your Staff Training

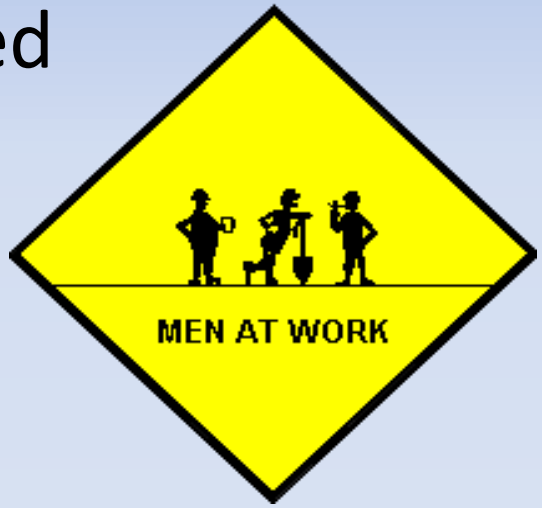
67. Sponsor is required to train their staff on the CACFP (e.g., completing meal count sheets, Income Eligibility Forms, calculating quantities, etc.). A minimum of one training must be listed and the date must coincide with the fiscal year for which application is made. Sponsor must document all CACFP/nutrition training provided to staff. Documentation includes dates and topics of training, list of attendees, certificates of attendance, etc.

Month:	May	Topic:	CACFP Requirements
Month:		Topic:	
Month:		Topic:	
Month:		Topic:	

Management Plans: Staff Training

handout

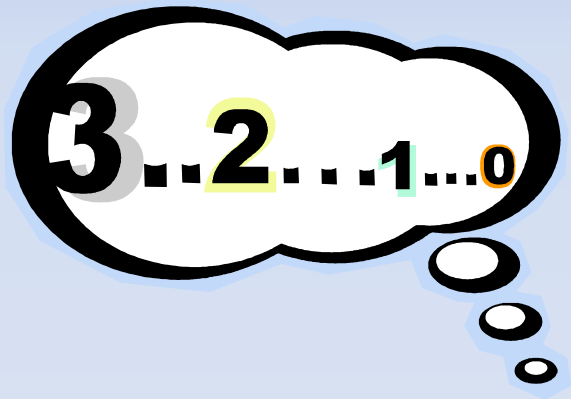
- Training MUST be documented
  - Date
  - Attendance
  - Topics covered



- NDE sessions do not fulfill requirement for YOU to train YOUR staff

Management Plan: Site Reviews

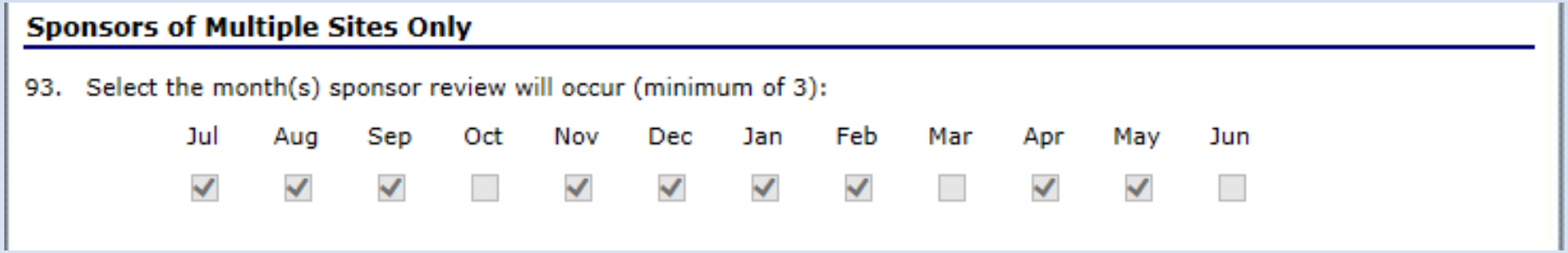
- Remember: 3, 2, 1
  - **3** site reviews each fiscal year
  - **2** unannounced
  - **1** must observe a meal service



- **5**-day reconciliation
- No more than **6 months** apart
- ***NEW*** form in May packet

Management Plan: Site Reviews

- Visits should be conducted according to management plan submitted
- Document the visit on the NEW site review form



Sponsors of Multiple Sites Only

93. Select the month(s) sponsor review will occur (minimum of 3):

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
☑	☑	☑	☐	☑	☑	☑	☑	☐	☑	☑	☐


DOOR
PRIZE

Agenda

May Packets/Application Renewals

Record Keeping/Regulations

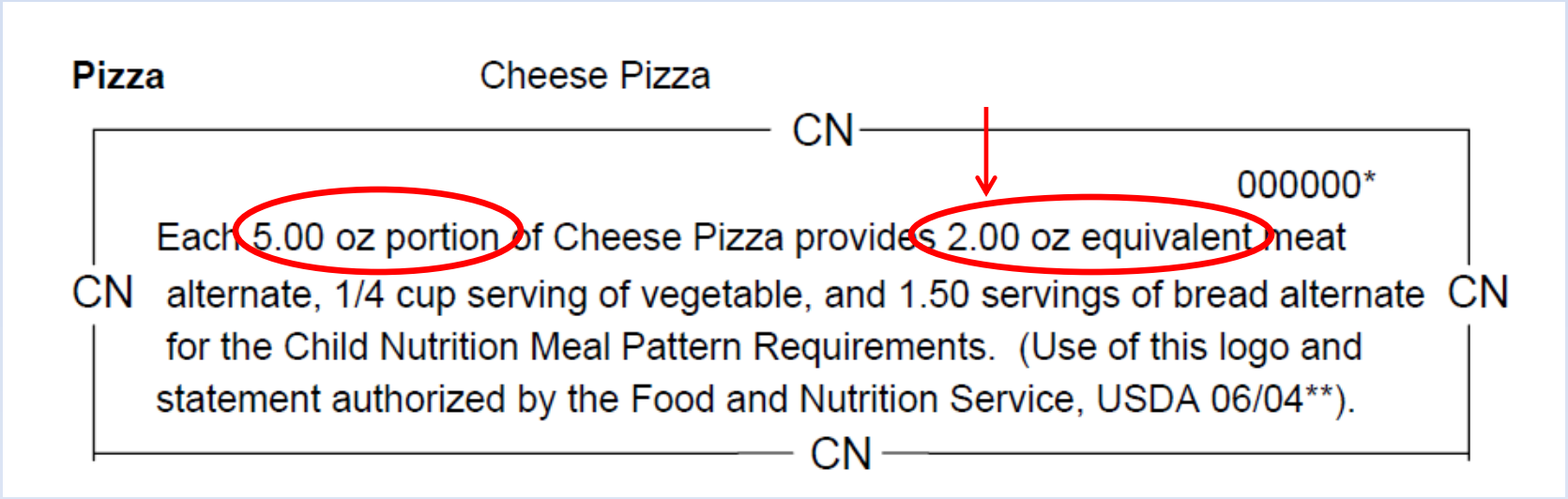
Crediting Foods/Infant Reminders

Crediting Handbook

- Use with *Food Buying Guide*
- Creditable foods:
  - Foods counted toward meal pattern requirements
- Non-creditable foods:
  - Foods that do not count toward meal pattern but do provide calories and nutrients
    - e.g. eggs served at breakfast

Child Nutrition (CN) Label

- Food manufacturer identifies food product's contribution to meal pattern requirements



How to document CN label foods

- 60 patties @ 2 oz meat, 1 oz grain/bread
- 150 nuggets (3 nuggets = 1.5 oz meat, 1 oz grain/bread)
- Recommend- make a copy of the CN label, take a picture of the CN label, attach the CN label to the menu production record

CN Label ≠ Nutritious

Example: CN label states 3 fish sticks = 0.5 oz meat

Q: How many fish sticks for a 1-year-old?

A: 6 sticks!

Q: How many fish sticks for a 6-year-old?

A: 12 sticks!

Product Formulation Statement

- Information sheet from food manufacturer
- Detailed explanation of product content and amount of each ingredient by weight

No CN Label?

MUST HAVE Product Formulation Statement!

Sample Product Formulation Statement (Product Analysis) for Meat/Meat Alternate (M/MA) Products

Child Nutrition Program operators should include a copy of the label from the purchased product carton in addition to the following information on letterhead signed by an official company representative.

Product Name:_____ Code No.:_____

Manufacturer:_____Case/Pack/Count/Portion/Size:_____

I. Meat/Meat Alternate

Please fill out the chart below to determine the creditable amount of Meat/Meat Alternate

Description of Creditable Ingredients per Food Buying Guide (FBG)	Ounces per Raw Portion of Creditable Ingredient	Multiply	FBG Yield/ Servings Per Unit	Creditable Amount *
		X		
		X		
		X		
A. Total Creditable M/MA Amount[1]				

*Creditable Amount - Multiply ounces per raw portion of creditable ingredient by the FBG Yield Information.

II. Alternate Protein Product (APP)

If the product contains APP, please fill out the chart below to determine the creditable amount of APP. If APP is used, you must provide documentation as described in Attachment A for each APP used.

Description of APP, manufacture's name, and code number	Ounces Dry APP Per Portion	Multiply	% of Protein As-Is*	Divide by 18**	Creditable Amount APP***
		X		÷ by 18	
		X		÷ by 18	
		X		÷ by 18	
B. Total Creditable APP Amount[1]					
C. TOTAL CREDITABLE AMOUNT (A + B rounded down to nearest ¼ oz)					

*Percent of Protein As-Is is provided on the attached APP documentation.
**18 is the percent of protein when fully hydrated.
***Creditable amount of APP equals ounces of Dry APP multiplied by the percent of protein as-is divided by 18.
[1]Total Creditable Amount must be rounded **down** to the nearest 0.25oz (1.49 would round down to 1.25 oz meat equivalent). Do **not** round up. If you are crediting M/MA and APP, you do not need to round down in box A (Total Creditable M/MA Amount) until after you have added the Total Creditable APP Amount from box B to box C.

Total weight (per portion) of product as purchased _____

Total creditable amount of product (per portion) _____
(Reminder: Total creditable amount cannot count for more than the total weight of product.)

I certify that the above information is true and correct and that a _____ ounce serving of the above product (ready for serving) contains _____ ounces of equivalent meat/meat alternate when prepared according to directions.

I further certify that any APP used in the product conforms to the Food and Nutrition Service Regulations (7 CFR Parts 210, 220, 225, 226, Appendix A) as demonstrated by the attached supplier documentation.

_____ _____
Signature Title

_____ _____ _____
Printed Name Date Phone Number

Standard of Identity

- FDA standards for content, preparation and food labeling
- Ingredients that foods must contain to be identified by that product name
  - Example: natural cheeses v. cheese products
- For consumer protection: foods meet expectations of the buyer

Chicken Nuggets

Food	Creditable			Comments
	Yes	Maybe	No	
Chicken Nuggets		x		Only the edible chicken portion is creditable as a meat. Commercial chicken nuggets must have a (1) CN label or (2) Product Formulation Statement signed by an official of the manufacturer (not a sales person). See question 11 on page 31 of this document. For breading/batter crediting, see the grains/breads section.

Turkey bacon, combination foods and chicken nuggets **MUST** have CN label or Product Formulation Statement (USDA Memo handout)

Examples:

- Meat sticks (summer sausage)
- Meat sauce
- Commercial pizza
- Polish sausage, other sausage
- Salami
- Pot pies
- Pizza
- Ravioli
- Burritos
- Corndogs
- Fish sticks

Hot dogs and bologna must <u>not contain</u> byproducts, cereal or extenders.

Extenders add “bulk” to foods without same nutritional value.

Hot Dogs

- No artificial flavors, colors, fillers or by-products

Note “all beef” on the menu production record

Byproducts, Cereals & Extenders

- Cereal
- Soy protein concentrate*
- Isolated soy protein*
- Sodium caseinate
- Starchy vegetable flour
- Vegetable starch
- Dry or dried whey
- Whey protein concentrate*
- Dried milk
- Soy flour*
- Wheat gluten
- Tapioca dextrin

*indicates Alternate Protein Product – may be OK but not all created “equal” so MUST obtain product specification

Milk

- Must be 1% or skim for children 2 years and older
- Whole is recommended for children 1 year old
- Document <u>milk type</u> on meal production record

Deductions will be made!

Milk Substitutes

- **NO** water or juice in lieu of milk. **EVER.**
- Only approved substitutes are creditable.
- See handout

What About Water?

- Required that water be available
- **NOT** meal pattern component
- **NOT** take the place of milk in meal pattern
- May be offered in addition to fluid milk at breakfast and lunch

Why Milk Substitutions?

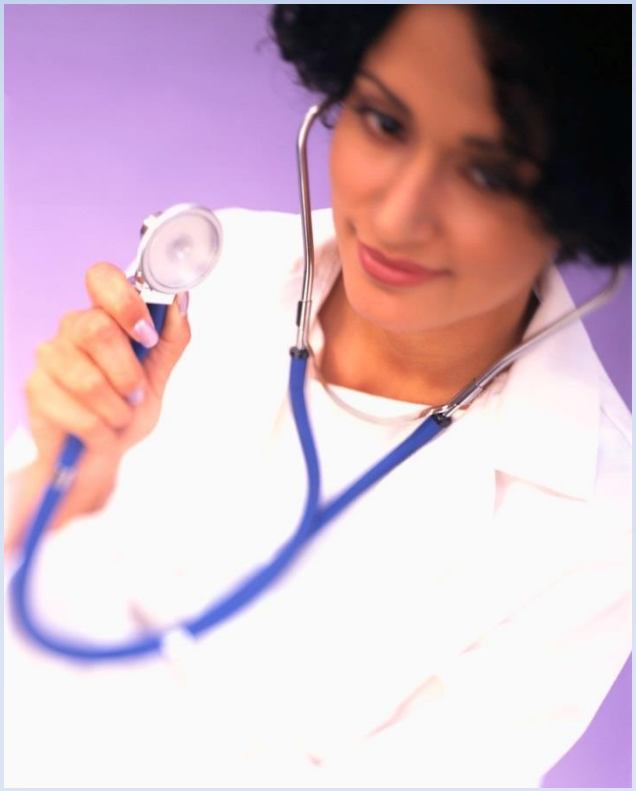
Disability

Intolerance

Parent request

Milk Substitute: Disability or Intolerance?

- Part B or C on Medical Statement completed by participant's physician
- Physician will determine whether allergy/intolerance is disabling or not
- Complete form in FULL
  - Food omitted, substitutes
- Signature required
- Disability is a Civil Rights protected class



Milk/Milk Substitute: Parent Request

- Parent completes Part A of Medical Statement
- Parent or center provides substitution

Q: Is it okay for a parent to request whole milk for a child older than 2?

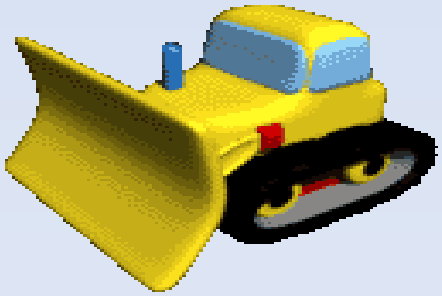
A: NO

Must meet meal pattern

Review

Milk: What If?

- No medical disability requiring alternate milk: center does NOT have to provide
- Parent brings approved milk substitute: center may claim the meals
- Parent requests water or juice: center **MAY NOT** claim



Infant Menu Reminders

Need to Specify:

- Type of fruit and vegetables – peaches, peas, etc.
- Type of infant cereal – oats, rice, wheat, etc.
- Breast milk or formula – prepare only the amount of breast milk the baby usually drinks at one feeding
- Amount prepared, not consumed

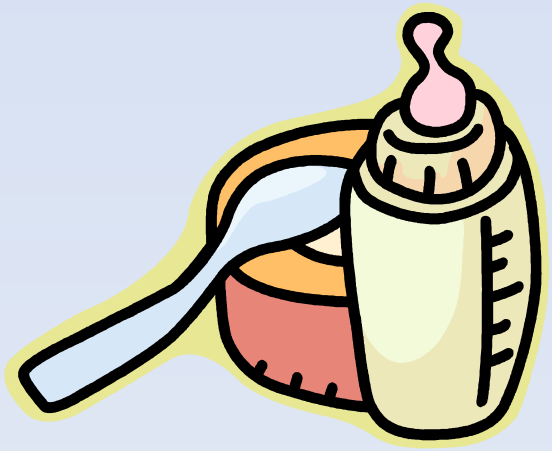
Infant Menu Reminders

- Foods not creditable include:
  - ✓ Hot dogs
  - ✓ Fish sticks
  - ✓ Nuggets (includes breaded chicken patty)
  - ✓ Combination commercial (jar) baby dinners such as chicken and noodles
  - ✓ "Desserts" such as Hawaiian Delight, Peach cobbler…

- For Combination table foods (example: goulash) only the meat is creditable (specify type)

Infant Cereal: Not just carbohydrates

- Infant cereal is fortified with iron
  - Infant iron storage is depleted by ~6 months old
  - Introduce infant cereal at 6 months old to provide source of iron
- Why is iron important:
  - Brain development
  - Prevent iron-deficiency anemia



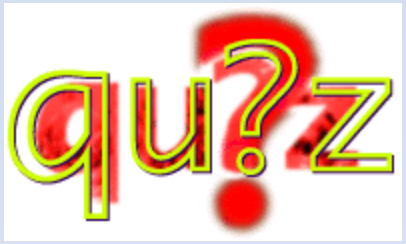
CACFP is a Privilege

Centers MUST follow all rules and regulations to be eligible to participate.

Federal Funds come with Federal/State Regulations


DOOR
PRIZE

Production Records



Example 1

DAILY PRODUCTION RECORD Day 2 Date: _____

NUMBER OF MEALS PLANNED

AGES	BREAKFAST	A.M. SNACK	LUNCH	P.M. SNACK	SUPPER	EVE SNACK
1 and 2 years						
3 through 5						
6 through 12						
Staff/Adults						

Milk. Whole milk and 2% milk may not be served to participants over two years of age.
*Whole = "W", Fat-free (skim) = "FF", Low-fat = "1%" e.g.: 1/2 gal. W and 2 gal. FF

MEAL PATTERN	MENU	FOOD DESCRIPTION	QUANTITY PREPARED
BREAKFAST 1) Milk, Fluid 2) Juice or Fruit or Vegetable 3) Grains/Breads (including cereal)	1) Milk 2) Cereal 3) Fruit	Cold Canned	1) 1 gallons * ___ and ___ gallons * ___ 2) 3 boxes 3) 2 #10 cans
A.M. SNACK (Select 2 different components) Milk, Fluid Juice or Fruit or Vegetable Meat or Meat Alternate Grains/Breads	1) Crackers 2) Juice		1) 2 boxes 2) 1½ gallons
LUNCH 1) Milk, Fluid 2) Meat/Meat Alternate 3) & 4) Vegetables and/or Fruits (two or more choices) 5) Grains/Breads	1) Milk 2) Chicken 3) Mandarin Oranges 4) Peaches 5) Salad/Cheese	Chicken Strips (CN Label)	1) 1 gallon * ___ and ___ gallons * ___ 2) 3-22 ozs 3) 4-11oz cups 4) 6-11oz cups 5) 3-12oz bags / 1-11oz bag 1-12oz bag
P.M. SNACK (Select 2 different components) Milk, Fluid Juice or Fruit or Vegetable Meat or Meat Alternate Grains/Breads	1) Graham Crackers 2) Bananas Water		1) 2 3/4 - 14.4oz boxes 2) 5lb Bunches
SUPPER 1) Milk, Fluid 2) Meat/Meat Alternate 3) & 4) Vegetables and/or Fruits (two or more choices) 5) Grains/Breads	1) Milk 2) Chicken/Cheese 3) Jello Fruit 4) Peas 5) Tortilla Shell	Chicken Strips	1) ½ gallons * FF and ___ gallons * ___ 2) 137ozs / 11oz 3) 4oz Fruit Jello cups 4) 130zs 5) 1-216ozs
EVE. SNACK (Select 2 different components) Milk, Fluid Juice or Fruit or Vegetable Meat or Meat Alternate Grains/Breads	1) ___ 2) Teddy Graham		1) 144 2) Bags 1oz

Example 2

DAILY PRODUCTION RECORD

Day & Date _____

NUMBER OF MEALS PLANNED

AGES	BREAKFAST	LUNCH	P.M. SNACK
1 and 2 years			
3 through 5			
6 through 12			
Adults in care & Staff			

Milk. Whole milk and 2% milk may not be served to participants over two years of age.
*Whole = "W", Fat-free (skim) = "FF", Low-fat = "1%" e.g.: 1/2 gal. W and 2 gal. FF

MEAL PATTERN	MENU	FOOD DESCRIPTION	QUANTITY PREPARED
BREAKFAST 1) Milk, Fluid 2) Juice or Fruit or Vegetable 3) Grains/Breads (including cereal)	1) Milk 2) Juice 3) Eggs		1) ___gallons *___ and ___gallons *___ 2) 2 Gallons 3) 4-12qty cartons
LUNCH 1) Milk, Fluid 2) Meat/Meat Alternate 3) & 4) Vegetables and/or Fruits (two or more choices) 5) Grains/Breads	1) Milk 2) Hamburger 3) Corn 4) Peaches 5) French Fries		1) ___gallons *___ and ___gallons *___ 2) 5lbs 3) 2#10cans 4) 2#10cans 5) 2 trays
P.M. SNACK **(Select 2 different components)** Milk, Fluid Juice or Fruit or Vegetable Meat or Meat Alternate Grains/Breads	1) Yogurt- 2) Milk	Strawberry	1) 60 cartons 2) 4 gallons

Example

DAILY PRODUCTION RECORD

Day & Date: _____

NUMBER OF MEALS PLANNED

AGES	BREAKFAST	LUNCH	P.M. SNACK
1 and 2 years			
3 through 5			
6 through 12			
Adults in care & Staff			

Milk. Whole milk and 2% milk may not be served to participants over two years of age.
*Whole = "W", Fat-free (skim) = "FF", Low-fat = "1%" e.g.: 1/2 gal. W and 2 gal. FF

MEAL PATTERN	MENU	FOOD DESCRIPTION	QUANTITY PREPARED
BREAKFAST 1) Milk, Fluid 2) Juice or Fruit or Vegetable 3) Grains/Breads (including cereal)	1) Milk 2) Juice 3) Toast		1) 2 gallons * 1% and 1/2 gallons * W 2) 2 gallons 3) 50 slices
LUNCH 1) Milk, Fluid 2) Meat/Meat Alternate 3) & 4) Vegetables and/or Fruits (two or more choices) 5) Grains/Breads	1) Milk 2) Hot dogs w/ Buns 3) 4) Cauliflower 5) Applesauce	 W/Dip 	1) ___ gallons * ___ and ___ gallons * ___ 2) 40 hot dogs 3) 4 lbs 4) 3 #10 cans 5)
P.M. SNACK **(Select 2 different components)** Milk, Fluid Juice or Fruit or Vegetable Meat or Meat Alternate Grains/Breads	1) Crackers 2) Juice		1) Handful - 40 servings 2) 2 gallons

Example 4

DAILY PRODUCTION RECORD

Day & Date: _____

NUMBER OF MEALS PLANNED

AGES	BREAKFAST	LUNCH	P.M. SNACK
1 and 2 years			
3 through 5			
6 through 12			
Adults in care & Staff			

Milk. Whole milk and 2% milk may not be served to participants over two years of age.
*Whole = "W", Fat-free (skim) = "FF", Low-fat = "1%" e.g.: 1/2 gal. W and 2 gal. FF

MEAL PATTERN	MENU	FOOD DESCRIPTION	QUANTITY PREPARED
BREAKFAST 1) Milk, Fluid 2) Juice or Fruit or Vegetable 3) Grains/Breads (including cereal)	1) Milk 2) Waffles 3) Melon		1) 4 gallons * 1% and ½ gallons * W 2) 23 waffles 3) 2 melons
LUNCH 1) Milk, Fluid 2) Meat/Meat Alternate 3) & 4) Vegetables and/or Fruits (two or more choices) 5) Grains/Breads	1) Milk 2) Chicken 3) Tater tots 4) Green Beans 5) Peaches		1) 6 gallons * 1% and ½ gallons * W 2) 4 boxes 3) 3 bags 4) 2 cans (big ones) 5) 2 cans (big ones)
P.M. SNACK **(Select 2 different components)** Milk, Fluid Juice or Fruit or Vegetable Meat or Meat Alternate Grains/Breads	1) Chips 2) Nacho Cheese		1) 4 ½ bags 2) 1 Can

Example 5

DAILY PRODUCTION RECORD

Day & Date: _____

NUMBER OF MEALS PLANNED

AGES	BREAKFAST	LUNCH	P.M. SNACK
1 and 2 years			
3 through 5			
6 through 12			
Adults in care & Staff			

Milk. Whole milk and 2% milk may not be served to participants over two years of age.
*Whole = "W", Fat-free (skim) = "FF", Low-fat = "1%" e.g.: 1/2 gal. W and 2 gal. FF

MEAL PATTERN	MENU	FOOD DESCRIPTION	QUANTITY PREPARED
BREAKFAST 1) Milk, Fluid 2) Juice or Fruit or Vegetable 3) Grains/Breads (including cereal)	1) Milk 2) Pineapple 3) Pancakes		1) ___gallons *___ and ___gallons *___ 2) 1/2 #10 can 3) 24 pancakes
LUNCH 1) Milk, Fluid 2) Meat/Meat Alternate 3) & 4) Vegetables and/or Fruits (two or more choices) 5) Grains/Breads	1) Milk 2) Baked Chicken 3) Mashed Potatoes 4) Green Beans 5) Peaches		1) ___gallons *___ and ___gallons *___ 2) 2 boxes 3) 2 lbs 4) 1-#10 can 5) 1-#10 can
P.M. SNACK **(Select 2 different components)** Milk, Fluid Juice or Fruit or Vegetable Meat or Meat Alternate Grains/Breads	1) Cheese 2) Bread	(Cheese Sandwich)	1) 1 - lb 2) 54 slices

Error Example 6

WEEKLY INFANT MEAL RECORD

Individual Infant - *8 through 11 Months

Site: Crazy Fun CCC

Child's Name: _____ D.O.B.: 6-15-14 Code: ____

See the *Crediting Foods in the Child and Adult Care Food Program* book for a list of creditable foods and minimum amounts to offer infants.

Dates		BREAKFAST All 3 components are required			AM SNACK		LUNCH All 3 components are required			PM SNACK		SUPPER All 3 components are required		
		Formula or Breast Milk 6 – 8 oz	Infant Cereal 2 – 4 T	Vegetable and/or Fruit 1 – 4 T	Formula, Breast Milk or Fruit Juice 2 – 4 oz	0 – 1/2 slice Bread or 0 – 2 Crackers	Formula or Breast Milk 6 – 8 oz	Infant Cereal 2 - 4 T and/or Meat, Fish, Poultry, Egg Yolk, Cheese 1 - 4 T	Vegetable and/or Fruit 1 – 4 T	Formula, Breast Milk or Fruit Juice 2 – 4 oz	0 – 1/2 slice Bread or 0 – 2 Crackers	Formula or Breast Milk 6 – 8 oz	Infant Cereal 2 - 4 T and/or Meat, Fish, Poultry, Egg Yolk, Cheese 1 - 4 T	Vegetable and/or Fruit 1 – 4 T
4/1	MON	6oz F	2T Cereal	2T Bananas			6oz F	2 Rice	2T Peaches			6oz F	2T Rice	Veggie
4/2	TUE	6oz F	2T Rice	2T Peaches			6oz F	2T Hamburger	2T Peas			6oz F	2T Rice	Fruit
4/3	WED	6oz F	½ Toast	2T Pears			6oz F	Pork	2T Pears 2T Peaches			6oz F	2T Rice	
4/5	THU	6oz F	Rice	2T Applesauce			6oz F	2T Rice	2T Bananas 2T Applesauce			6oz F	2T Rice	Fruit
4/6	FRI	6oz F	2T Peaches	2T Pears			6oz Juice	2T Rice	3T Peaches			6oz F	2T Rice	
—	SAT													
—	SUN													

OF EDUCATION

Error Example 7

WEEKLY INFANT MEAL RECORD
Individual Infant - *8 through 11 Months

Site: Crazy Fun CCC

Child's Name: Abby Ricketts D.O.B.: 7-11-14 Code: ____

See the *Crediting Foods in the Child and Adult Care Food Program* book for a list of creditable foods and minimum amounts to offer infants.

Dates		BREAKFAST All 3 components are required			AM SNACK		LUNCH All 3 components are required			PM SNACK		SUPPER All 3 components are required		
		Formula or Breast Milk 6 – 8 oz	Infant Cereal 2 – 4 T	Vegetable and/or Fruit 1 – 4 T	Formula, Breast Milk or Fruit Juice 2 – 4 oz	0 – 1/2 slice Bread or 0 – 2 Crackers	Formula or Breast Milk 6 – 8 oz	Infant Cereal 2 - 4 T and/or Meat, Fish, Poultry, Egg Yolk, Cheese 1 - 4 T	Vegetable and/or Fruit 1 – 4 T	Formula, Breast Milk or Fruit Juice 2 – 4 oz	0 – 1/2 slice Bread or 0 – 2 Crackers	Formula or Breast Milk 6 – 8 oz	Infant Cereal 2 - 4 T and/or Meat, Fish, Poultry, Egg Yolk, Cheese 1 - 4 T	Vegetable and/or Fruit 1 – 4 T
4/1	MON	5oz BM	3T Lucky Charms	3T Fruit			5oz BM	3T Veggie	3T Fruit	Juice		5oz BM		2T Peas 2T Peaches
4/2	TUE	5oz BM	1 Mini-Muffin	3T Veggie			5oz BM	3T Noodle & Beef	2T Veggie	Juice		5oz BM	Slice of Cheese	2T Veggie
4/3	WED	5oz BM	1 French toast stick	3T Bananas			5oz BM	1/4 Cheese burger	3T Peaches	5oz BM		Juice	Hot dog	2T Applesauce
4/4	THU	5oz BM	1/2 toast	3T Veggie			5oz BM	3T Roast Beef	2T mashed potatoes	Juice		5oz BM	2 Chicken Nuggets	3T Peas
4/5	FRI	5oz BM	3T Capt. Crunch	3T Pears			5oz BM	1/2 Cheese pizza slice	3T green beans	5oz BM		5oz BM	2T Hamburger	2T Applesauce
—	SAT													
—	SUN													

4th Meals?

This form must be used in combination with a point of service meal count sheet, i.e. blue and white Record of Meals and Supplements Served forms.